HETEROSOCIAL SKILLS TRAINING WITH SEX OFFENDERS

BY

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The purpose of this study was to determine the effectiveness of a heterosocial skills training module with sex offenders. A randomized control group, posttest-only design tested four major null hypotheses and three null sub-hypotheses. The dependent variables of heterosocial skill, heterosocial self-esteem and heterosocial anxiety were measured with three criterion instruments: (1) The Heterosocial Skills Behavior Checklist (HSB), (2) The Social Self-Esteem Inventory (SSI) modified for this study, and (3) the S-R Inventory of Anxiousness (SRIA).

Forty incarcerated sex offenders at the North Florida Evaluation and Treatment Center in Gainesville, Florida,

were assigned to treatment or control groups. The treatment group was further divided randomly into two groups of 10 subjects each.

The eight lesson training module was completed in five weeks. Two sets of male/female co-trainers implemented the heterosocial skills module. Role play and videotape feedback activities directed attention to three problem areas: (a) negative self-talk, (b) performance anxiety, and (c) heterosexual skills deficits. Female co-trainers and female volunteers simulated social conversations with the offenders.

Following training, self-report posttests were administered and videotapes were made of all subjects in a role play conversation with a female confederate. Using the HSB, subjects' behaviors were rated.

All hypotheses were stated in the null form and were tested at the .05 level of confidence. A two-way analysis of variance was used to test for differences on the dependent variables as well as interaction between treatment and type of offense.

Significant differences were found between groups on HSB total (p.02) and voice subscale scores (p.02). Form of conversation and affect subscales approached significance. Self-esteem and anxiety measures yielded non-significant results. In addition, no significant differences were found between rapists and pedophiles in their responses to treatment.

Data indicated that the module was effective in increasing heterosocial skill in incarcerated sex offenders. Recommendations were discussed for further research and implementation of the treatment module.

CHAPTER I
INTRODUCTION

Sexual offenses have increased steadily in the United States. For example, reported rape has risen by 557 percent in the past 40 years (Chappell, Geis, & Geis, 1977). In 1979, nearly 76,000 forcible rapes of women were reported to the FBI, an increase of 20 percent in just two years (FBI Uniform Crime Reports, 1980). Awareness of sex offenses has been encouraged by the women's liberation movement. In addition, expanding social and family services, such as spouse and child abuse centers, have also heightened public awareness and concern.

Rape, child molestation, and incest are crimes that have traditionally been dealt with through prison sentences. However, 31 states now have laws which make special treatment possible for some sex offenders who are found to be "mentally disordered" or "sexually deviated" (Brecher, 1978).

Except for a few community-centered programs, most sex offenders are securely incarcerated in a variety of state institutional settings including prison and forensic hospital programs. Within the limitations imposed by budgets and public support, these treatment programs attempt to alter the personality and behavior of the offender, thus preventing future offenses.

Although sex offender treatment has more than a 30-year history, most of the 16 major inpatient programs currently operating in the United States are less than 10 years old (Brecher, 1978; Weinrott, 1980). Early programs were psychoanalytically oriented. More recently, behavioral theories and techniques have been used. Since current theories stress faulty or insufficient learning in the developmental years, contemporary treatment often consists of specific training in deficit areas such as sex education, assertiveness training, and interpersonal communication skills. However, there is a need to design and implement a systematic training program that will help sex offenders develop more approriate and adequate skills in relating to the opposite sex.

Need for the Study

There is a need for controlled experimental studies dealing with the social skills of sex offenders. Although offenders tend to be socially immature, their interpersonal problems manifest themselves most notably in their relationships and interactions with the opposite sex. Laws and Serber (1975), working at Atascadero State Hospital in California, concluded that most sex offenders were incapable of appropriate heterosexual relations.

Marshall et al. (1978) reported the following;

> Social ineptitude has been noted as a common feature of rapists and pedophiles by clinicians

> of diverse background . . . and this appears to involve both deficiencies in interpersonal skills and anxiety associated with social interaction. Furthermore, we have noted in our own treatment program . . . that lack of self-confidence interferes with effective social functioning in sex offenders. Other researchers have also noted the important role of self-esteem in sexual behavior. (p. 2)

Yet, with a few notable exceptions (see Chapter II), systematic attempts to remediate social skills deficits, to reduce heterosocial anxiety or to enhance heterosocial self-esteem in sex offenders have not been a part of treatment. Administrative problems in acquiring females for role play purposes and the lack of female staff have sometimes been cited for this failure. As a result, the effectiveness of heterosocial skills training with sex offenders remains at the case report or single subjects design level (Abel, Blanchard, & Becker, 1977).

Research with minimal dating or shy college students accounts for most of the available literature on heterosocial skills training. Curren (1977), for example, reviewed several successful attempts to enhance social skills and decrease social anxiety in this population. Citing screening and recruiting methods which selected a "less anxious" population, he stated a need to test the effectiveness of social skills training with a more clinically-distressed population. Sex offenders represent such a population.

A central problem in all social skills research has been the availability and reliability of dependent measures. Those specific measurable behaviors which reflect social adequacy or inadequacy seem to have eluded researchers (Hersen & Bellack, 1979). A study may have shed some light on the problem. After comparing the performance of a group to sexual deviates and a group of similar aged males identified by their female friends as adequate, it became apparent that specific motor skills, the amount of affect displayed, and components of voice and flow of conversation, clearly discriminated between the two groups. The authors developed the Heterosexual Skills Behavior Checklist (HSB) and recommended its use in future studies (Barlow, Abel, Blanchard, Bristol, & Young, 1977). There is a need for more information that can be collected with this measure.

Less expensive and more accountable systems of treating sex offenders need to be found. Criticism of treatment programs in Florida, for example, has led to the adoption of a "sunset" provision in the statute governing sex offenders.

Sex offender programs are generally supported by state tax money. Frequently, program budgets are less than adequate and the staff-to-resident ratio is often unfavorably high. Treatment efficiency in relation to time and number of staff is very important. In addition, many of the direct care positions are staffed by paraprofessionals with limited training in therapeutic theories and methods. Therefore, an

organized training module with lesson-by-lesson procedures and measurable objectives would benefit the taxpayer, the program staff, and offenders.

A training module to assist sex offenders in the development of social skills was developed by the investigator. Training components feature role playing with confederates, video feedback, and didactic material. Variables related to heterosexual skill, anxiety, and self-esteem will be measured. There is a need to examine its efficacy in an experimental design.

Purpose of the Study

It is the purpose of this study to develop a social skills treatment program for incarcerated sex offenders and to investigate its effectiveness. In addition, the following research questions will be examined:

1) If sex offenders participate in a six-week training module, will their heterosexual skills be measurably increased?

2) If sex offenders participate in the training module, will their heterosocial anxiety be measurably decreased?

3) If sex offenders participate in the the training module, will their heterosocial self-esteem be increased?

4) Is there a relationship between the type of criminal offense and effectiveness of the training?

Definition of Terms

For the purposes of this study, the following definitions will be used:

1) Heterosocial skills--interpersonal behaviors necessary to initiate and maintain a conversation with a member of the opposite sex.

2) Heterosocial anxiety--anxiety experienced as a result of an interaction with, or an anticipated interaction with, a member of the opposite sex.

3) Heterosocial self-esteem--an individual's assessment of his adequacy in performing sexual and social role behaviors.

4) Sexual offender--an incarcerated person convicted of a sexual offense under Florida statutes (i.e., rape, child molestation, exhibitionism, or incest) and determined to be suffering from a psychosexual disorder.

5) Confederate--females who volunteer for role playing activities and work cooperatively with the investigator and trainers.

6) Forensic hospital--a state-supported mental health facility designed for treatment of sex offenders--those found incompetent to stand trial, or who are "not guilty" by reason of insanity, or who are psychiatric referrals from the prison system.

7) Psychosexual disorder--a psychological dysfunction marked by fantasies and/or acts of engaging in illegal and socially unacceptable sexual behavior.

8) Sexual offense--a sex act which is contrary to society's existing mores and results in a legal conviction.

Organization of the Study

The remainder of this study is organized into four additional chapters and appendices. Chapter II contains a review of the literature and further established the rationale for the study. The research design, hypotheses to be tested and the experimental variables are described in Chapter III. The results of the study are reported in Chapter IV. Chapter V includes a summary of the study, conclusions and recommendations.

CHAPTER II
REVIEW OF THE LITERATURE

Extent of the Problem

Any attempt to describe the extent of the problem of sexual offenses in the United States is difficult at best. Child molestation and, in particular, incest frequently go undetected, unreported, and unprosecuted (Groth, 1978). Estimates of unreported rape range from 70-90 percent, making it the most under-reported of all serious crimes (Amir, 1971).

Although statistics are unavailable as to whether or not the rate of child molestation is changing, forcible rape appears to have been on the increase for many years. FBI statistics show that violent crime, in general, rose 170 percent between 1933 and 1973, but reported rape increased 557 percent (Chappell et al., 1977).

It is suggested by some researchers that these increases are more apparent than real, reflecting more relaxed attitudes toward sex and therefore more reporting. More sophisticated data gathering methods have also been cited as a possible cause for the increased numbers. However, the majority of researchers are of the opinion that a real and dramatic per capita increase in sex offenses, particularly forcible rape, has been occurring for many years (Chappell et al., 1977; Amir, 1971; Groth, 1979; MacNamara & Sagarin, 1977).

> In Florida, in 1971, forcible rapes numbered 1,708 and represented 4.4 percent of all violent crimes. In 1979, these crimes totaled 4,573 and represented 10.4 percent of all violent crimes. The 1979 figure also represented a 15.5 percent increase over 1978, and the rate of increase appears to be accelerating. The number of arrests for other sex offenses increased from 2,668 in 1971 to 4,781 in 1979, with the rate per 100,000 persons rising from 37.9 to 51.7 percent. The number of reported sexual assaults on minor children appears to be increasing with rape reports and this acceleration follows a national trend. (Crime in Florida, 1975, p. 22)

Defining a sexual offense can be a problem since sexual attitudes and mores frequently change, according to time, place, and cultural context. Consequently, laws governing sexual behavior vary considerably. Some states, for example, still prohibit certain consenting acts between husband and wife (Gebhard, Gagnon, Pomeroy, & Christenson, 1965). Adult homosexual relations in private are illegal in 36 of the 50 states. Even in states where such acts are legal, however, there are diverse interpretations of what constitutes adulthood, consent, and privacy (MacNamara & Sagarin, 1977). With regard to this issue, Gebhard et al. (1965) and others concluded:

> Data obtained from a study of 1,500 sex offenders are interpreted to show that there are two broad categories of sex offenses: (1) Offenses which are statistically normal and which the public and professionals would consider within cultural norms, such as sexual activity with willing post-pubescent unrelated females. Such offenses do not threaten society and psychological damage to the individuals is generally absent. Social measures

> should therefore be tempered accordingly and a minimum of time and money should be spent with such cases. (2) Offenses which are statistically uncommon and which the public and most professionals would consider outside cultural norms or pathological, such as those offenses involving force, those in which children are victims, incest, and exhibition. These offenses are more likely to disrupt social organization and the possibility of psychological damage is greater. Society should focus its efforts on these offenses and be prepared to spend money for treatment and research. (p. 873)

According to Gebhard and his colleagues (1965), a sexual offense is ". . . an overt act committed by a person for his own immediate sexual gratification which (a) is contrary to the prevailing sexual mores of the society in which he lives and/or is legally punishable and (b) results in being legally convicted" (p. 8).

Early writings often included crimes which now go unprosecuted (Karpman, 1954). Currently, the professional literature focuses attention almost exclusively on the following types of sexual crimes (Brecher, 1978):

(a) Acts involving force or duress, such as rape

(b) Sexual contact with children

(c) Acts in public which are deemed a public nuisance.

Rape

The fastest growing crimes, according to FBI statistics, are those of violence, and rape is the fastest growing crimein this category. In 1975, there were 56.000 reported rapes in the U.S. (MacNamara & Sagarin, 1977). Contrary to popular belief,

rape is not just a big city problem. In recent years (1960-1973), the sharpest increase has occurred in cities with populations between 50,000 and 100,000 (Chappell et al., 1977).

Who are the victims of rape? A victim is typically a single female between the ages of 16 and 19. A woman in this age group is three times more likely to be raped than other women. She will likely be of the same race and socioeconomic status has her assailant. The offender is likely to be about five years her senior (Chappell et al., 1977).

Studies differ with respect to the frequency of lone versus pair or gang rapes. About 91 percent of the 348 offenders in one study acted alone (Groth, 1979). Another study found over 50 percent of the white victims were assaulted by more than one attacker (Chappell et al, 1977). Brownmiller (1975) cited three studies in which 30 percent, 43 percent, and 50 percent of arrests for rape involved multiple offenders.

The effects of rape on the victim vary depending on the type of rape, the rapist, characteristics of the victim, and the victim's social support system. Generally, rape victims describe the experience as one of the most traumatic of their lives.

> The assault triggers an acute disruption of the victim's physiological, psychological, social and sexual lifestyle as evidenced by somatic problems, disturbances in sleeping and eating patterns, and development of minor mood swings and fears specific to the circumstances of the assault. (Groth, 1979, p. 61)

Following the attack, the victim usually experiences a heightened sense of powerlessness and vulnerability. Although the psychological impact is the most problematic and lasting, physical damage can serve as a continual reminder of the event.

A rape trauma syndrome has been identified by Burgess and Holmstrom (1974) consisting of three phases:

1) The acute reaction phase is characterized by shock, disbelief, and dismay. The victim is usually in an agitated, incoherent and highly volatile state for a few days to a few weeks.

2) In the outward adjustment phase, the victim appears to have put the trauma aside, getting on with life as usual. The duration of this phase is brief and is a result of the victim's normal attempt to deny and/or cope superficially with the rape.

3) The integration and resolution phase is characterized by depression as the victim's defenses weaken. The victim must face and work through the issues which remain. She must integrate a new view of herself and resolve her feelings about her assailant(s).

Sexual Contact with Children

The lack of reliable crime rate statistics for child molestation is the result not only of under-reporting, but also the number of different legal statutes under which this

crime can be prosecuted. Indecent exposure, indecent assault, open and gross lewdness, contributing to the delinquency of a minor, carnal abuse, sexual battery, sodomy, and incest are all charges which could be pressed for this offense (Groth, 1978).

In 1973, members of the Children's Division of the American Humane Association testified before a Senate committee and claimed that 100,000 children are sexually abused each year. Although other estimates are higher (Largen, 1978), they remain only guesses. One reason for our ignorance of the extent of child molestation appears to be our lack of willingness to face and deal with it realistically. Sgroi (1978) stated that "sexual abuse of children is crime society abhors in the abstract, but tolerates in reality" (p. xv).

Incest is receiving national attention through books, magazine articles and television (Brady, 1981). The incidence of incest reported by researchers varies greatly with the population being surveyed. Hallack (1962) reported that 15 percent of a group of teenage girls confined to a state training school had had sex with their fathers or stepfathers. Other studies of disturbed or delinquent populations yield similarly high rates of between 10 and 25 percent. Research at the Kinsey Institute, however, yielded a much lower 4 percent incidence of incest (Meiselman, 1978).

Christie, Marshall and Lanthier (1979), found that 74 percent of the victims of incarcerated pedophiles in their

study were acquainted with the offender. Swanson (1968) found 76 percent were known to the victim. Other studies have shown the same trend (Mohr, 1962). Christie et al. (1979) also found that 60 percent of the offenses against children took place while the offender was a guest in the victim's home, or while the child was visiting a home of a friend.

Frequently, the victim is related to the offender. Although the incest offender can be a sibling, grandfather or uncle, the majority of arrests are for father-daughter incest (Meiselman, 1978). In these cases, the offender can be the biological or the functional parent. A sexual relationship may develop slowly over years and progress from fondling to intercourse, or it could be a sudden impulsive act triggered by situational stress (Groth, 1978; Giarretto, 1976).

Victim impact. Burgess and Holmstrom (1978a) identified the victimization problems which result from child molestation. The first type is rape trauma, in which the victim experiences the assault as life-threatening. In a large number of child rapes, multiple offenders are involved. The instability of the younger victim make recovery potentially more difficult than for the older rape victim.

The second type is termed the accessory-to-sex syndrome. This occurs when the child is pressured into sex by a person who stands in some power position with respect to age or

authority. Additional stress is caused by the pressure to maintain secrecy. Noticeable symptoms typically develop if the relationship continues, such as crying, withdrawal, or excessive baths (Burgess & Holmstrom, 1978b).

Masters and Johnson (1970) state that the psychological effects of child molestation depend on the age when it occurs and the amount of guilt and anxiety engendered. Female adolescent victims typically express significant guilt and depression. Reactions include running away from home, promiscuity and drug abuse.

Seigel (1974) cited four factors which were related to the severity of the trauma experienced by the victim. The victim is likely to suffer more intense and long-lasting effects if (a) the relationship was an emotionally close one, (b) the contacts were repeated over a long period of time, (c) the physical contact was intense (i.e., penetration), or (d) there was a high degree of force or violence involved.

A dramatic illustration in the long term effects of incest is portrayed in The Last Taboo (1977), a 30-minute film of the highlights of a weekend marathon encounter group. The group was comprised of women in their twenties who were incest victims as children. Through role play, using males as father surrogates, unresolved psychological issues surface and are expressed. Severe social and psychological problems such as frigidity, prostitution, drug addiction, and alcoholism were traceable to the incest trauma.

Public Nuisance Acts

The most common of the so-called nuisance offenses prohibited by law are exhibitionism, voyeurism, and obscene communications by phone or letter. Continuous exhibitionism is perhaps the most common of all sex offenses (Gebhard et al., 1965). An exhibitionist is a person for whom the exhibiting of his genitalia is a desired end in itself. In a recent survey of sex offenders in treatment, rapists and child molesters were found to have participated at an early age in window peeping, exhibitionism, and a variety of other "nuisance" offenses (Groth, Longo, & McFadin, in press). Frequently, this behavior represents a developmental stage in their movement toward rape or child molestation, and some offenders continue to exhibit themselves after committing more serious offenses.

Little is known about the psychological harm to the victim of an exhibitionist, or voyeur, or obscene phone caller. Fear, shock, and disgust are the most common reactions by adults. The short or long term impact on children is difficult to assess and has not been discussed in the literature.

Summary. The literature on sex offenders and offenses tells a story of human desperation and human misery. Although according to statistics, the extent of the problem is large and increasing, there are strong indications that undetected sex offenses are even greater in number (Groth et al., in press).

The impact on the victims of sex crimes is a recent field of study energized by the women's liberation movement and the interest in child abuse and neglect. All indications are that the physical, social, and psychological damage inflicted on victims of sex offenses is severe. In many cases, the total ramifications of being a victim are not felt until much later. This is evidenced by the number of offenders who were victims themselves (Groth & Longo, 1981).

Characteristics of the Offender

Numerous descriptive studies have been conducted in order to develop a profile of the sex offender (e.g., Karpman, 1954; Gebhard, Gagnon, Pomeroy, & Christenson, 1965; Amir, 1971; MacDonald, 1971; Christie, Marshall, & Lanthier, 1979). Although little empirical research has been conducted with regard to the personality of the sex offender, the professional literature is replete with clinical impressions taken from years of contact with this population in prison and treatment centers.

Several of these studies have compared and contrasted the two major subtypes of sex offenders, rapists and child molesters. Others present classification systems which differentiate offenders into subgroups, usually according to choice of object or psychological motive (Cohen, Seghorn & Calmas, 1969; Rada, 1976; Groth, 1979; Christie et al., 1979).

General Demographic Characteristics

Most rapists are relatively youthful, usually in their early twenties. Amir's study (1971) in Philadelphia was typical, finding the mean age of the rapist to be 23 years. Rapists in the Christie et al. (1979) study averaged 27 years of age; however, this study was conducted in a maximum security prison with a high percentage of older repeat offenders and career criminals. Brownmiller (1975) emphasizes that rape is a crime of violence which, like other crimes of aggression, tends to be committed by the young. Groth found that most repeat rapists commit their first offense or attempt by age 16 (Groth et al., in press).

Educational level and intelligence level of rapists approximate the norm for their age group. Mean grade level achieved was the eleventh in most studies with the mean I.Q. following a normal distribution. Karpman (1954) reviewed the literature between 1912 and 1951 and found I.Q. scores to be normal or above, and normally distributed. Educational level was low but no comparison was made with respect to sex offenders and others of the same age and socioeconomic level.

Studies differ with respect to race and rape. The differences seemed to be attributable to the population studied. Amir's population (1971) was taken from inner city Philadelphia in 1960. He found 82 percent of all rapists arrested

were black. Yet, a Wisconsin study (Pacht, et al., 1962) revealed that six times more whites were convicted of rape.

In 1968 in the United States, whites accounted for 51 percent of rape arrests, and blacks, 47 percent. Blacks were approximately 15 percent of the population that year. A study of 253 rapists in Denver (1962-1969) revealed the following racial and ethnic differences among rapists: whites, 35 percent, Hispanics, 34 percent; and blacks, 30 percent (MacDonald, 1971).

In contrast to the rapist, the child molester tends to be older. In one study of 1,195 cases, only 28 percent of the child molesters were under 30, as compared to 75 percent with a rape charge (Henn, Herjanic, & Vanderpearl, 1976). Of the rapists in MacDonald's study mentioned above, 50 percent were below 15 and 25 years of age with 75 percent below the age of 30.

Although a male child molester's I.Q. is average, he tends to be an under-achiever educationally (Christie et al., 1979). He remains unmarried more frequently than the norm. When he does marry, his divorce rate is lower than the rapist's (Gebhard et al., 1965). Child molesters have fewer non-sex related crimes than rapists. Rapists, for instance, have been found to display more aggressive and antisocial features than other sex offenders and they often have histories of other criminal or violent behavior. Although offenders frequently blame or rationalize their behavior on

alcohol and other drugs, the majority of offenders were not intoxicated at the time of their offense (Groth, 1978).

The authors and reviewers of these descriptive studies caution readers against drawing hasty conclusions from their data. For example, Christie et al. (1979) and Martinsen (1974) state that the poverty of the rapists and pedophiles in their studies could be the result of the judicial process favoring those who can afford the best lawyers and who appear to have been productive members of society.

Psychological Characteristics of the Offender

The earliest and most comprehensive attempt to classify and describe sex offenders resulted in Karpman's work published in 1954. This was the first book devoted entirely to the sex offender. Gebhard and others at the Institute for Sex Research published a survey describing the various types of sex offenders in 1965. Others have refined and added to these two pioneering works, most notably Pacht et al. (1962), Cohen et al. (1969), MacDonald (1971), Rada (1976) and Groth (1979).

Two broad general distinctions between offenders appear in the literature. The first refers to the degree of criminality or sociopathy present. Some offenders' behavior is caused primarily by the presence of a psychosexual disorder, while another's sex offense may be attributable primarily to their antisocial personality. There is agreement among

researchers that this group should not be considered primarily as sexually deviant persons (Cohen, Garafalo, Boucher, & Seghorn, 1977).

The second distinction drawn is between the offender whose deviant behavior was due to a situational, transient reaction to stress imposed by external circumstances, and the offender whose behavior is primarily the result of internal psychological dynamics (Groth, 1979). These distinctions have important implications, particularly when treatment programs are available.

The Rapist

In general, the rapist is a man with serious psychological problems. These problems handicap him severely, particularly in his relationships with others. Typically he is unable to form emotionally close relationships with males or females. The relationships he does form are characterized by a lack of sharing, warmth or trust. Although he may be intellectually competent, his judgment is usually poor, especially when stressed. His awareness of himself is usually limited, as well as his awareness of the needs and feelings of others. He harbors deep-seated doubts about his adequacy, particularly in his role as a man (Rada, 1976; Groth, 1979).

Because of his maladaptive social attitudes and behavior, the rapist is typically a loner, with few real friends.

He also finds few satisfactions in other spheres of his life. He takes little pride in his work, or his hobbies. "Having developed few avenues of personal expression, he attempts to rectify the situation . . . through sexuality and aggression" (Groth, 1979, p. 108).

Attempts have been made to categorize or type rapists. Cohen et al. (1977) cautioned against simplistic and superficial categorization of offenders, referring to the multidimensional nature of the factors involved in the act of rape. They go on, nevertheless, to propose three patterns of offenses differing in terms of motivation:

1) Aggressive Aim: Sex is in the service of aggression. It is a vehicle for its expression. The offender describes his emotional state as one of anger.

2) Sexual Aim: Clearly motivated by sexual wishes, the offender's aggression is in service of this aim. Force is used to subdue the victim so sex can take place.

3) Sex-agression Diffusion: Aggression and hostility have become eroticized. Inflicting pain is necessary for excitement and gratification.

According to Groth (1979), rape is the use of sexuality to express power or anger. In this sense, it is a pseudo-sexual act. He goes on to present a typology, not unlike Cohen's, but stressing power as a dominant motivating factor.

Power rapist. Power rapists account for the majority of all rapes. The power rapist's goal is sexual conquest to

bolster his sense of masculine adequacy. He wants to possess his victim and may kidnap her and rape her repeatedly. Since he perceives it as a test of his masculinity, the rape is a mixture of excitement, anxiety, anticipated pleasure and fear. He also fears women and their control over him. He frequently has intense unacknowledged dependency needs which give women an exaggerated power over him. Frequently, he experiences sexual dysfunction during the rape and almost never finds it sexually satisfying. He will typically distort his perceptions of the victim's enjoyment. His lack of satisfaction only increases his compulsion to find the "right" victim who, he imagines, will be so impressed with him she will respond with abandon and ask to see him again.

This type of offender may commit a series of rapes in a short period of time. His aggressiveness may increase as he becomes more desperate in his attempts to actualize his fantasies; however, he typically only uses enough force to subdue his victim. He may use a weapon but only to invoke fear and maintain control. His offenses can be either premeditated or opportunistic and may be triggered by an event which undermines his sense of competency or self-esteem (Groth, 1979).

Anger rapist. This type of offender considers rape the ultimate offense against another person. He considers sex dirty and therefore uses it to hurt, humiliate and degrade his victims. Satisfaction and relief are attained more

through the discharge of anger than the sex act itself. He typically uses far more force to subdue his victim than is necessary. Frequently the victim sustains enough physical trauma to require medical attention.

The anger rapist does not plan his attack and is frequently surprised and somewhat disbelieving in his own behavior after the fact. This type of rape is usually triggered by an identifiable precipitating event in which the offender feels annoyed, put down or hurt, in particular by a woman. The anger that results from his frustration and hurt is displaced frequently on an unsuspecting victim in an impulsive burst of violence. Although the anger rape may be more frequently reported, this type of offender appears to be outnumbered by the power rapist, contributing to approximately 30 percent of all rapes (Groth, 1979).

Sadistic rapist. Sex and aggression become fused in this type of offender. Inflicting pain on another is all that is necessary for satisfaction in some of these offenders and only a necessary preliminary for sex in others. The more aggressive they are, the more powerful and excited they feel. They thrive on a feeling of omnipotence. Frequently, they are fascinated by the morbid, occult, violent and bizarre, hence the ritualistic overtone of some of their offenses. Although this type of offender is rare, he gets a disproportionate amount of attention in newspapers and the

media because he occasionally murders his victim in his frenzied attack (Groth, 1979).

The Pedophile

Typically referred to as child molestation, pedophilia does represent a clinical diagnostic category. However, these offenders are far from a homogeneous group.

As was true of the rapist, it is important to make a distinction between the sexually deviated pedophile who finds children preferred objects and the antisocial personality whose sexual abuse of a child reflects a pattern of general aggressive and antisocial behavior. In addition, certain forms of severe psychopathology can also result in this behavior. "This includes alcoholics, schizophrenics and older individuals where brain deterioration has led to a weakening of normal inhibitory controls. In fact, pedophilia and exhibitionism are the most common sex offenses committed by senile and arteriosclerotic individuals" (Masters & Johnson, 1970, p. 57).

Sexually deviated pedophiles are generally socially and sexually immature. They are usually passive, compliant men with dependent and inadequate personalities. They find the demands and responsibilities of adult life, particularly the interpersonal and heterosexual demands, stressful and threatening. Their family life was typically filled with conflict or they were overprotected and controlled as children.

Clinical experience with this group of offenders indicate a high incidence of victimization or exposure to some type of sexual trauma in the pedophile's own childhood (Prendergast, 1980).

Regarding etiology, psychodynamic interpretations stress the fixated or regressive aspects of this behavior (Cohen et al., 1969; Groth, 1979). More behaviorally-oriented interpretations stress the conditioning and faulty learning of the offender (Able et al., 1977).

Typically this offender finds children attractive initially because they are less threatening and are easily manipulated and controlled. The appeal of their hairless, asexual bodies represents, at least initially, a fear and denial of adult sexuality. After numerous sexual contacts, the physical appearance begins to be associated with sexual pleasure and becomes highly attractive and sexually appealing (Laws, 1980).

Like the rapist, the pedophile can be subtyped according to certain personality features and sex object choice. Once again, Groth's (1978) typology appears to be the more complete.

The fixated pedophile. This offender typically has a lengthy history of sexual contact with children. Their own sex play with peers when they were children often continues uninterrupted into adulthood. They are frequently shy, passive, socially awkward individuals who have difficulty

relating with others in the adult heterosexual or homosexual world.

Their sexual knowledge is limited and attitudes and sexual identity are immature. They remain unmarried far beyond their age group, but they can achieve a stable marriage or lasting relationship with someone who has a complimentary personality (Christie et al., 1979). They generally establish a relationship with a child over a period of time, slowly gaining trust. Their sexual acts with children are almost always premeditated. Courting behavior is often mistaken for simple kindness and generosity. Many times their vocational choices put them into close proximity with children (e.g., counselors, little league coaches, teachers).

The fixated pedophiles' sexual contact with children is usually limited to smelling, mutual fondling, sucking and caressing. Their motivation seems to be for affection, warmth and closeness. They frequently report falling in love with one or more of their victims. A longing for contact with children is usually intense, similar to an addiction or compulsion (Laws, 1980). Adult contact, on the other hand, is avoided out of fear and feelings of inadequacy.

The Regressed Pedophile. This offender's psychosexual and social development appears to be normal. However, he harbors deep unresolved feelings of inadequacy. As responsibilities of adult life mount, his self image and feelings of competency are further challenged.

Frequently, this offender is married. A crisis in his relationship with his wife, perhaps a financial setback, an illness, or a vocational failure could precipitate the sexual behavior with children. Although the behavior is contrary to his values, he is depressed and his controls are weak. His sexual contact with adults normally continues during this same period. His behavior is desperate and an unconscious effort to cope with a specific life-crisis.

A further categorization is offered by Groth (1978), this time with respect to the psychological aim underlying the pedophile's behavior.

> Child sexual assault is equivalent to a symptom and like the dynamics of any symptom it serves to gratify a wish, to defend against anxiety and to express an unresolved conflict. The nature of the interaction between the offender and his victim reveals his motivational intent and the determinants prompting his selection of a child for a sexual contact. Such offenses can be classified into two basic categories: pressured sex contact and forced sex contact. (p. 11)

In the pressured sex contact, the offender either entices the child through persuasion or cajolement. He might trap the child through creating an indebtedness or obligation. He often bribes the child with gifts, good times, or promises. The aim is to have the child consent willingly to his advances.

In the forced sex contact, the offender uses intimidation or physical aggression to gain control over his victim.

Groth further divides this category into exploitive and sadistic assault. The forcefully exploitive sexual offender is looking for sexual gratification and a feeling of power. The child is simply an object over which he can extend control. As in power rape, sex is being used as a vehicle to relieve nonsexual needs for power, control and dominance. The child is usually not harmed, if he or she cooperates. But, this offender is capable of harming his victim physically.

Like the sadistic rapist of adults, the sadistic child offender derives pleasure from inflicting pain. Here sex and aggression are fused and a brutal sexual attack occurs. In the extreme cases, the offender finally kills his victim (Groth, 1978).

The Incest Offender

Most of the different forms of pedophiliac behavior can and do occur within a family context. With regard to the complicating issues, Groth (1978) stated:

> In pedophilia we are primarily dealing with the dynamics of an individual, whereas in every case of parental incest, there is some form of family dysfunction. The interrelationships among all of the nuclear family must be examined, the structure of the family network as well as the dynamics of the participants. (p. 19)

The incest offender turns to his daughter as a way of achieving what he has failed to get from his mate. He is

frequently a dependent individual and transfers this dependency to his child. Because he cannot provide his wife with the emotional support she needs, she may look elsewhere for male companionship. She frequently feels resentment and even contempt for him and becomes inattentive to his needs. He then turns to his daughter as a surrogate wife-mother because this is a relationship which he can still control (Groth, 1978).

Regarding the type of incest offenders, Meiselman (1978, p. 111) offers a classification system presented in Table 1. The number of offenders in each category depends on the setting. For example, an urban population of offenders would yield few in the endogamic-subcultural category.

Sex Offender Treatment

In the 10 years between 1948 and 1958, the first four treatment programs for sex offenders were established in California, Wisconsin, Massachusetts and Washington. These programs resulted from changes in the laws of those four states with respect to individuals convicted of sex offenses. Changes in the laws identified sex offenders as a special category of criminal whose deviant behavior reflected a mental illness.

Prior to 1948, sex offenders were sentenced to long prison terms with little or no chance at psychological

TABLE 2.1
CLASSIFICATION OF INCESTUOUS FATHERS*

Endogamic	Heavily dependent on family for emotional and sexual needs Unwilling to unable to satisfy sexual needs outside the family
Personality Disorder	Shy and ineffectual in social relations Intellectual defense structure and tendency to paranoid thinking Intensely involved with daughter, overcontrolling of her Sometimes preoccupied with sex Often involved with prepubescent daughter
Subcultural Variety	Lives in isolated rural area Moralistic, periodically atoning for sins Social milieu semitolerant of incest Usually involved with postpubertal daughter
Psychopath	Criminal history Sexually promiscuous, unrestrained by marital bonds Little emotional attachment to daughter
Psychotic	Severe ego disorganization of organic of functional origin
Drunken	Incest occurs only when father is extremely intoxicated
Pedophilic	Generally attracted to young children as sex partners May lose interest in daughter as she ages
Mental defective	Low intelligence a factor in reduced ego controls
Situational	Incest occurring only during high-stress period for father

*(Meiselman, 1978)

treatment. This is still the case in 35 of the 50 states today (Brecher, 1978).

The Sex Offender Laws

The "sexual psychopath" laws represented an advance in treatment because they recognized the sex offender as a psychologically disturbed individual in need of special help. However, these laws have also been used in some states to confine prisoners for longer periods of time than might have been possible under the usual statutes (MacDonald, 1971).

Bowman and Engle (1965) summarize the legal and medical objections to the sexual psychopath laws:

> It is objected that due process and equal protection . . . are denied, especially the right to counsel, to jury trial, to appeal. . . . Also . . . the right against self-incrimination and the rights of subpoenaing witnesses and cross examination. The medical objections are the difficulties of diagnosis and identification of the sexual psychopath, the limitation of criminal responsibility, the ineffectiveness of treatment and the inadequate statistics. (p. 757)

Alabama and Pennsylvania have both had their sex offender statutes repealed. In Pennsylvania, the Barr-Walker Act (1954) provided for indeterminant confinement and treatment for the "sexual psychopath." In 1966, this law was declared unconstitutional on the grounds that the offender did not have the opportunity to cross examine the psychiatrist who recommended commitment. The Alabama statute also paid

little attention to the constitutional rights of the offender and has recently been repealed (MacNamara & Sagarin, 1977).

Probably the most glaring inadequacy of the early laws and the systems which grew out of them was their failure to provide specific treatment. Defense attorneys continued to point out this omission. Brecher (1978) emphasized that "a sexual psychopath could be kept locked up until treatment was successfully completed. . . . The likelihood that they could win release as 'cured' was severely impaired, of course, by the fact that no treatment was provided them during their incarceration" (p. 39).

Wisconsin's law, enacted in 1947, is more adequate. It recognizes the psychological nature of many sex offenses. It protects the constitutional rights of the offender and provides the necessary administrative and clinical machinery necessary for effective diagnosis and treatment, Pacht, 1976).

A crucial issue facing the courts and the entire medical/legal system is the question of a convicted offender's appropriateness for treatment. Wisconsin developed a classification system to aid in this determination. This system is

> . . . based on a continuum which is bounded on one side by the crime committed, primarily as a result of sociological or cultural factors and on the other extreme, by crimes committed almost entirely because of psychological determinants. (Pacht et al., 1962, p. 804)

An offender in Wisconsin is evaluted for 60 days. During this time, he is tested and interviewed. If he is found to be sexually deviated, he is placed in a special program within the prison system. If he is found not to be suffering from a psychosexual disorder, he is sent to a regular correctional facility (Pacht et al., 1962).

Treatment Programs and Methods

In a survey of 292 state, county and private hospitals, Di Furia and Mees (1964) found considerable diversity in providing sex offenders treatment. Only 10 percent of the hospitals surveyed offered a separate program for sex offenders. Eighteen percent offered no treatment and 71 percent treated sex offenders along with other patients.

According to this survey, median length of sex offender treatment was a little over one year. The major criterion for success in these programs was better adjustment with family, jobs and friends. The problem with follow-up was as acute as it is today.

Treatment approaches were drawn mainly from nondirective and psychoanalytic theories, with very few of the programs surveyed favoring a behavioral approach. According to self-reports, professional staff in these programs showed little confidence in their success. Over half of the respondents surveyed stated that, "Some are helped, most are not."

Not all early attempts at treatment were as inadequate, however. Between 1948 and 1954, the Metropolitan State Hospital in Norwalk, California, developed an exemplary program. Although few written traces of the program remain, Doctors Alfred Kinsey and Wordell Pomeroy, the eminent sex researchers, were impressed by their visit (Brecher, 1978).

Without any successful model to follow, the staff at Norwalk developed a program which produced a low, 5 percent return rate, in contrast to a 20 to 50 percent return in other groups. The patients were allowed to wear their street clothes. Wives and family could visit them in their quarters. There was unlimited and uncensored correspondence, a therapeutic work program and women therapists were part of the staff. Inmates could "fire" any guard they didn't like. Probably most impressive was the program's ability to generate a 24-hour-a-day therapy milieu in which the inmates had intense investment. Unfortunately, the effectiveness of this program was lost when the State of California built the $20 million Atascadero State Hospital where all sex offenders were subsequently sent (Brecher, 1978).

According to Brecher (1978) in his survey of sex offender treatment programs in the United States, 1972 marked a turning point. Three new treatment programs were founded in that year. Within the next four years, 12 more were founded. Also in 1972, a call for new approaches to the

problem was published by a Maryland psychiatrist, Dr. H.L.P. Resnik, and a Pennsylvania criminologist, Professor Marvin Wolfgang. Some of Wolfgang and Resnik's proposals have found their way into the more innovative treatment programs. These include sex re-education, participation of wives, personalizing the victim, use of female co-therapists, and treatment of sexual inadequacy.

Brecher's survey of 20 sex offender treatment programs included both institutional and community based. Five institutional programs are described in some detail, two of which are described here.

In Washington, Fort Steilacoom's Self Help Program includes four basic objectives: (a) the offender must learn to recognize his own antisocial behavior patterns; (b) he must understand the origins, development, and operations of those patterns; (c) he must accept responsibility for his deviant behavior and make a commitment to change; and (d) he must develop new patterns of behavior which will gain him community acceptance.

This model is called "guided self-help." The offenders meet in intensive group sessions, with no staff present. Supervision is close, however, with staff playing a guidance and consultative role. Couples therapy, the use of female volunteers for role playings and work release are among the other therapeutic methods employed. A graduated 12-step

program, as in Alcoholic Anonymous, is used to recognize each offender's progress through treatment.

The ROARE Program was pioneered at Rahway State Prison in New Jersey, by Dr. William Prendergast, Jr. ROARE stands for Re-education of Attitudes and Repressed Emotions and emphasizes regression accompanied by emotional catharsis of repressed childhood sexual trauma. ROARE has evolved into a more comprehensive program with the building of New Jersey's new facility in Avenel. It is the only facility in the United States specifically designed for sex offenders. A sophisticated video-feedback system is now employed to help offenders and therapists analyze problems and the treatment process.

The Avenel program also has a Patient Directed Responsibility program (PDR).

> A PDR program participant decides for himself the form which a therapy session shall take, what other participants or staff members he wants present and so on. On some occasions, he may choose to be alone in the studio, engaging in a soliloquy or "acting out" his feelings--for subsequent replay by him and his therapist. (p. 45)

Common elements. Dr. Gene Abel et al. (1978), behavioral psychologists, described five common elements in treatment programs for rapists. Since few programs group offenders by crime, these elements could apply to all sex offenders in treatment.

1. Empathic relationship. Whatever the theoretical orientation of the program, the importance of a warm accepting relationship between the rapist and therapist is seen as a necessary prerequisite for treatment effectiveness.

2. Confrontation. Although specific methods differ, all programs stress the importance of confronting the offender with his responsibility for the offense. The offender is confronted on any use of denial, rationalization or minimization of his responsibility for his deviate behavior.

3. Heterosocial-heterosexual skills training. The majority of programs stress the need for development of skills which facilitate appropriate interaction with adult females. Frequently, this is done through individual role play with female staff or with volunteers. Unfortunately, many institutional settings make this type of interaction difficult or impossible.

4. Increasing sexual arousal to adult females. Some rapists indicate that mutually enjoyable or consensual intercourse is not erotic to them and that force or coercion is a necessary element in their sexual arousal. Psychodynamically-oriented therapies involve the exploration of the fears that are assumed to underlie this lack of arousal. Behavioral methods of treatment of this problem include systematic desensitization, fading and masturbatory reconditioning.

5. Decreasing sexual arousal to rape. As in the previous element, while psychodynamic therapies use a variety of insight-oriented and indirect methods of accomplishing this goal, the behaviorists use covert desensitization and aversion techniques. Whatever approach is used, the de-eroticizing of the precipitating stimuli is the ultimate object of all sex offender treatment programs.

Group therapy. Whether offender-led or staff-led, most programs use group therapy as the primary treatment modality. In early programs, this method was used initially out of necessity, given insufficient trained staff to conduct individual therapy sessions. However, programs soon found that the peer group and the pressure for responsibility, honesty, and change it exerts, are a potentially potent therapeutic force. The group forms a type of surrogate family which provides the support necessary for risk-taking and change (MacDonald, 1971; Brecher, 1978).

Behavior modification. The behavioral approach to the treatment of sex offenders, pioneered by men like Dr. Gene Abel, at the University of Tennessee, Memphis, and Dr. D.R. Laws, at Atascadero State Hospital in California, is having widespread influence on sex offender treatment.

Stressing faulty learning and early conditioning as causative factors, the objectives of treatment are (a) the reduction of deviant sexual arousal, (b) the development of

appropriate arousal patterns, and (c) the acquisition of social skills (Abel et al., 1978).

For the purposes of accomplishing (a) and (b) above, precise and direct methods of assessing sexual arousal had to be developed. In his review of the physiological methods of assessing arousal (known as pallography), Zuckerman (1971) concluded that direct calibration of penile erection was superior to all other measures.

Of the most successful devices used to measure sexual arousal in males, Abel et al. (1978) stated:

> Numerous reports of apparatus to measure penile circumference have been published. Most of the circumferential devices are elastic tubes encircling the penis, which are filled with either water, mercury or graphite. As tumescence occurs, the elastic tubing lengthens around the penis, causing contractions of the inner diameter of the tubing. With changes of this inner diameter, calibration of penile size is possible. (p. 170)

Coupled with audio and video presentations of sexual stimuli, this technology can be very useful in assessment of deviant sexual arousal. This also has important implications for treatment. For example, a child molester may demonstrate arousal to 10-year-old boys, but also to adult women. One rapist may exhibit arousal to a relatively nonviolent rape scene but no arousal to a video tape of a woman being beaten. For another rapist, the beating scene may be the most stimulating. These findings would influence

clinical decisions regarding diagnosis, prognosis, and treatment. Penile devices can be employed in behavioral treatment, as discussed earlier, through the use of various conditioning paradigms such as fading, covert sensitization and aversion techniques (Laws, 1980).

As clinicians and researchers in this area have discovered, altering an offender's sexual arousal is frequently not enough. Barlow (1977) stated:

> Therapists and clinical researchers working with procedures to change patterns of sexual arousal have noted the insufficiency of these efforts alone in establishing functional heterosexual behavior in many cases. Whether the treatment goal is increasing heterosexual arousal, decreasing deviant arousal, or both, many patients are unable to date or successfully relate to persons of the opposite sex despite successful modification of arousal patterns. . . . [S]ocial skills deficits in heterosexual situations are responsible for these failures. (p. 230)

Heterosocial skills training is a re-educative approach designed to aid the offender in establishing and maintaining appropriate social and sexual relationships.

The need for this type of training with sex offenders and group studies to test its effectiveness has been called for repeatedly in the literature (Abel et al., 1978; Pacht, 1976).

> Social skills training is particularly intriguing in sex offenders because it is in part directed toward teaching the individual the skills necessary for establishing mature interpersonal

> relationships. Despite the theoretical promise of this approach, it needs considerable research before definite statements can be made about its effectiveness. (Pacht, 1976, p. 96)

Social Skills and Heterosocial Skill Literature

It is only within the past 20 years that social skills have become a focus of study. In the 1960's, a series of studies conducted by Zigler and his colleagues were carried out which demonstrated a significant relationship between social competence and level of psychiatric impairment. Low social competence was associated with more severe symptomatology and more difficulty in post-hospital adjustment (Hersen & Bellack, 1977; Zigler & Phillips, 1961, 1962). In the 25-year report of the psychotherapy project at Johns Hopkins University, Frank (1974) cites improved social skill as one of the two beneficial aspects of short term psychotherapy.

Eisler (1976), in reviewing these earlier studies, found that the discovery of the importance of social skills did not spawn new treatment strategies designed to improve the social skills of psychiatric patients. Some researchers fault the psychodynamically-oriented therapies for this shortcoming. Speaking to this point, Hersen and Bellack (1977) cite the "vague and undefined relationship between the diagnostic process, and the ensuing therapy" characteristic of the traditional psychodynamic approach (p. 511).

According to behaviorists, the psychodynamic approach acknowledges the existence of poor interpersonal adjustment but focuses treatment on symptom removal or unstructured attempts to improve socializing through group therapy.

In contrast, the behavioral approach offers a one-to-one relationship between diagnostic assessment and consequent treatment strategies. Thus the relevance of the treatment to the patient's specific problem areas is enhanced. In addition, the assessment techniques which grew out of the traditional approach, despite their sophistication, failed to predict how an individual would behave under a given set of social environmental circumstances.

Eisler (1976) cites three reasons for the predictive failure of the traditional approach: (a) personality alone was assumed to account for poor performance and the effect of the social environment was ignored; (b) classification of interactional observations were hampered by the global definitions of the personality variables leading to inaccurate and unreliable measures, and (c) an almost total reliance on self report, which precluded aspects of the person's behavior that may be beyond his awareness.

From a behavioral perspective, the basis of social competence is a set of learned abilities called social skills:

> People must learn how to interact in the same manner that they learn to swim, play the violin or play bridge. Interpersonal failures

> result with faulty learning histories leave the individual with social skills deficits. (Hersen & Bellack, 1979, p. ix)

The success of social skills training is being credited to behavior therapy. In fact, it is considered by some as one of its most significant achievements (Hersen & Bellack, 1979).

Heterosocial Skills

Heterosocial skills are "those skills necessary for social interchange between members of the opposite sex" (Galassi & Galassi, 1979, p. 131). Although heterosocial skills can include a broad range of behaviors, research has focused almost exclusively on behaviors relevant to initiating contact between shy or minimal dating college students.

Although progress has been made toward understanding the parameters of heterosocial skill in the past few years, this area of study is still embrionic. For example, although consistent agreement can be found between raters when comparing levels of social skills in individuals, the specific behaviors which account for those differences have yet to be determined empirically (Curren, 1977; Eisler, 1976; Hersen & Bellack, 1977). Arkowitz et al. (1975) analyzed the behavior of high and low frequency daters on seven behavioral components, such as head nods, number of smiles, talk time and silences. They found the only behavioral dimension

which discriminated high and low daters was silences, high frequency daters having had fewer.

Galassi and Galassi (1979) summarized the situation regarding assessment:

> For males, the search for specific behavior and anxiety indices has not been encouraging. In any one investigation only a few of the indices reveal any differences. The specific indices that have differentiated heterosocially competent and incompetent males include: heart rate and specific anxiety signs; initiating interactions and responding verbally to approach cues; response timing and placement; voice, affect, and form of conversation; verbal content measures; obtaining a date in a phone call; talk time; number of silences; and response latency. Unfortunately, these findings are not replicated across studies, and there appears to be no consistent pattern. (p. 139)

The verbal and nonverbal behavioral sequences emitted and responded to during interpersonal action are very complex. Also, behaviors deemed "skillful" on one context (on a date) could be judged inappropriate in another (job interview). Norms also differ with respect to culture, age and socioeconomic status. Thus, it is not only the observed behavior which must be judged as relatively skilled or unskilled, but the interaction of those behaviors within a specific interpersonal context. These judgments are further influenced by the values and norms held by specific groups of observers (Eisler, 1976).

Kupke and Hobbs (1979) liken the current search for valid behavioral indices of social anxiety to early attempts to

validate intellectual functioning. "Relatively simple tests of basic sensory and motor abilities failed while the uses of more complex tasks proved quite successful" (p. 329). In this regard, Arkowitz et al. (1975) call for "a study of social skills differences based on behavioral measures which take into account the reciprocal and the interactive characteristics of the dyadic interaction" (p. 11).

Theoretical Differences

Four classes of variables have been postulated as being responsible for social inadequacy--conditional anxiety, skills deficits, cognitive distortions and physical attractiveness (Curren, 1977; Galassi & Galassi, 1979).

Those who favor anxiety as the basis of poor social performance hypothesize that the individual has learned the correct response and anxiety is inhibiting performance (Wolpe & Lazarus, 1966). The skills advocates theorize that due to lack of experience, faulty learning or learning disabilities, the individual doesn't possess the skills for competent performance (Curren, 1977).

Another explanation of poor social skills concerns cognitive evaluations and distortions. Due to "negative self evaluations, high performance standards, unrealistic expectations, irrational beliefs, faulty perceptions or misinterpretations of feedback" (Galassi & Galassi, 1979, p. 138), the individual's interactions are inadequate. Finally,

physical attractiveness is receiving more attention concerning its role in heterosocial problems. Less attractive individuals, according to this view, may have fewer opportunities to practice and develop skills. They may be rated as less skillful regardless of their skill level (Galassi & Galassi, 1979).

Problems of Definition

In light of the theoretical differences and methodological problems just cited, a single operational definition of social skill which applies to many contexts seems nearly impossible. The literature defines social skills variably as (a) those interpersonal behaviors that contribute to individual effectiveness as part of a larger group (Argyris, 1965), (b) the "complex ability to maximize the rate of positive reinforcement and to minimize the strength of punishment from others" (Libet & Lewinsohn, 1973, p. 34), and (c) the ability to develop rapport and express interest and understanding in a social interaction (Weiss, 1968). Curren (1979) believes we need to develop a narrow, motor-skill based definition of social skill. He believes that at the present time, definition is the most fundamental problem in the study of social skill.

> The definitional problem affects all the other issues in the field. Our definition of the construct not only affects the content of what we train, but also how we construct out training programs. It affects what we decide to

> measure and how we decide to measure it. It affects the manner in which we select subjects, the types of control groups we employ and how we choose to analyze our data. (p. 325)

Heterosocial skills per se has been defined by Barlow et al. (1977) as skills relevant to initiating, maintaining and terminating a social and/or sexual relationship with a member of the opposite sex. Since different skills are required in different stages of a relationship, more meaning can be derived from definitions which are more specific to either initiating or maintaining (Galassi & Galassi, 1979).

Research

Three general areas account for the majority of research in social skills: (1) research with psychiatric population, (2) assertiveness studies, and (3) heterosocial skills training with minimal dating college students.

Goldsmith and McFall (1975) found that when male psychiatric inpatients were given only three hours of interpersonal skills training, they demonstrated significantly greater improvements than control groups in ability to handle difficult interpersonal situations. Finch and Wallace (1977) gave a group of male schizophrenic inpatients 12 sessions of social skills training. The skill group, when compared with a group of matched control subjects, demonstrated greater improvement on seven separate dimensions of social skills.

Rathus (1972) conducted two studies designed to determine the effectiveness of assertiveness training with female undergraduates. The first study demonstrated a decrease in general and specific fears related to social competence. In the second study, the assertiveness-trained participants were rated as significantly more assertive than controls on the basis of five audio taped responses to structured questions.

McFall and Marston (1970) conducted a study with 42 non-assertive college students. Subjects were assigned randomly to two control groups (placebo and no treatment) or two treatment groups (one with performance feedback and one without). Both self-report and behavioral measures yielded significant improvement of the experimental over the control groups.

Curren (1977), in his review, divides the literature according to the three major assumptions concerning the etiology and maintenance of heterosexual social inadequacy: (a) conditioned anxiety, (b) faulty cognitive processes, and (c) skills deficits.

Borkovec et al. (1974) supported the anxiety theory by demonstrating that low and high anxious subjects could be successfully discriminated in a heterosocial role play situation. While heart rate, self-reported anxiety and observers rating did discriminate high and low anxious subjects, the majority of the behavioral measures did not. In two

additional studies growing out of the conditioned anxiety theory, systematic desensitization was successfully used to decrease fear response associated with heterosocial sexual situations (Bander, Steinke, Allen, & Mosher, 1975; Curren & Gilbert, 1975). Typically, in these studies, treatment consisted of working through fear hierarchies by pairing relaxation training with increasingly fearful stimuli. Finally, the individual participated in an actual face-to-face role play or real dating situation.

The second explanation of heterosocial anxiety views the individual's faulty cognitive/evaluative appraisal of his performance and his expectation of negative consequences as the source of the problem. In support of this theory, Clark and Arkowitz (1975) found high anxious subjects underestimated their own performance in a heterosocial role play. Smith and Sarason (1975) demonstrated that high socially anxious individuals possessed a high generalized need to be liked, were highly motivated to avoid disapproval and were overly concerned with others' evaluations of them.

Curren (1977) focused most of his review of the literature on the third assumption--that "the source of the anxiety in the heterosocial sexual interaction is partially reactive and due to an inadequate, inappropriate behavioral repertoire" (p. 141). He cites several investigators (Arkowitz et al., 1975; Borkovec et al., 1974; Twentyman & McFall, 1975) who have been able to demonstrate differences

between low and high heterosexually socially anxious individuals on global ratings of skill, performance and heterosexual social interaction situations.

Curren uses Bandura's (1969) label, the response acquisition approach, in describing the treatment model adapted in these studies. A variety of methods were used to help the heterosocially shy individuals overcome their problems, such as modeling, behavioral rehearsal, and self-observation from video.

Although 13 studies were reviewed, only a few, according to Curren, were sufficiently free of methodological shortcomings to warrant serious consideration of their findings. He praised Twentyman and McFall's (1975) study for its attempt to demonstrate the construct validity of its assessment devices. In this study, 31 college students who scored low on the Survey of Heterosocial Interactions were assigned to treatment or control groups. Treatment included modeling, behavioral rehearsal with female assistants coaching, audio feedback and repetition. Results indicated significant group differences on an array of measures including self-report, physiological, global and specific anxiety ratings and ratings of skill anxiety and conversation duration during social behavioral situations.

In another well-controlled study, cited by Curren, 45 heterosexually anxious and shy males were selected for participation in a social skills training program. They were

randomly assigned to one of two treatment groups (behavioral rehearsal or behavioral rehearsal plus homework) or to a control group. Treatment consisted of discriminating between approachable and unapproachable females, initiating and maintaining conversations, telephone skills, and responding accurately to nonverbal cues (MacDonald, Lindquist, Kramer, McGrath, & Rhyne, 1975). Curren (1977) states that "the results from the MacDonald et al. 1975 study can generally be taken as supportive of the response acquisition model for treatment of heterosexual social anxiety" (p. 142).

CHAPTER III
METHODOLOGY

The purpose of this study was to assess the effectiveness of a six-week training module on the heterosocial skills, heterosocial anxiety, and heterosocial self-esteem of incarcerated sex offenders. The study comprised treatment and control groups selected from the same population. The treatment group was divided into two groups of 10 persons each, all of whom received the same heterosocial skills training. The control group did not receive the treatment module until after the study were completed. Data was collected on both groups and were analyzed statistically to determine significant differences. This chapter describes the experimental procedures.

Population

The population for the study consisted of residents of the North Florida Evaluation and Treatment Center (NFETC) in Gainesville, Florida. NFETC is one of three forensic hospitals in Florida under the Department of Health and Rehabilitative Services (HRS), Mental Health Division. Of the 215 residents, 63 were sex offenders.

Sex offenders are sent to this facility from a committing court or from the Department of Corrections after (a) being found guilty of a sex offense (e.g., rape, child molestation, exhibitionism) and (b) being found, after a screening evaluation, to have a psychosexual disorder. Of the 63 offenders, approximately 15 percent were black, 5 percent Hispanic, and 80 percent white. The mean age was 26, with a range in age from 16 to 60. The mean level of education attained was tenth grade, with socioeconomic level being typically lower middle class. Nearly 70 percent were single with 15 percent married and 15 percent divorced or separated.

Less than one-third of the residents in the sex offender program were committed to NFETC by the court. They were convicted of a sex offense, found to meet the criteria of a Mentally Disordered Sex Offender by a minimum of two court-appointed programs currently in operation in Florida. Before this law was altered, under Chapter 917.12 of the Florida Statutes, sentencing was withheld pending outcome of treatment.

The treatment programs must make periodic reports to the court concerning an offender's progress. Once treatment is completed, an offender is returned to the court for further disposition. The program's report, as well as other factors, determines whether the offender is placed on probation or sentenced to prison.

In August, 1979, Chapter 917 was changed. Under the new law, an offender is either placed on probation or sentenced to prison. On arrival in the Department of Corrections system, the offender is screened by a Joint Department of Corrections/Department of Health and Rehabilitative Services team. If the offender meets the following criteria, he is placed on a waiting list for transfer to one of the three HRS sex offender treatment programs in Florida: (1) has a psychosexual disorder; (2) did not murder or attempt to murder his victim(s); (3) has a sentence between 1 and 11 years, and (4) is motivated and able to accept treatment. Those offenders who meet the above criteria but have a sentence longer than 11 years are placed on a waiting list for future consideration three years prior to parole.

Each resident goes through an intensive evaluation on entry. During the initial evaluation stage, the resident's willingness and ability to benefit from treatment are assessed. At the end of this 60 to 90 day period, he is either accepted into treatment (lasting 18 to 36 months) or is returned to the Department of Corrections to finish his sentence.

There are three buildings to which a sex offender might be assigned on arrival. A building consists of two to three living areas or "pods." Each pod contains nine separate resident rooms, and a common "living room" area for socializing, TV watching, group therapy, and pod business meetings. The

pods are separated by a secure control room where NFETC treatment staff maintain three 24-hour shifts.

One professional staff member acts as primary therapist for each pod. In addition, paraprofessional staff perform observation, charting and daily maintenance functions. The primary treatment modalities in all three buildings include group therapy four times a week, individual or small group consultations, and specialized short term training groups such as substance abuse, sex education, or stress management training.

Research Design

A randomized control group posttest only design (Isaac & Michaels, 1971) was used to test four major hypotheses and three subhypotheses. This design was chosen because previous research suggested that the Heterosocial Skills Behavior Checklist (HSB) was a highly reactive instrument (Alexander, 1979). In addition to reducing interaction effects of pretest and experimental procedure, the experimental design controled for the effects of history and maturation (Isaac & Michaels, 1971).

Hypotheses

Four major null hypotheses and three null subhypotheses were tested:

Ho 1) There will be no significant difference between experimental and control groups on the variable of Heterosocial Skills, as measured by the Heterosocial Skills Behavior Checklist (HSB).

Ho 1a) There will be no significant difference between experimental and control groups on the variable of voice, as measured by the HSB.

Ho 1b) There will be no significant difference between experimental and control groups on the variable of form of conversation, as measured by the HSB.

Ho 1c) There will be no significant difference between experimental and control groups on the variable of affect, as measured by the HSB.

Ho 2) There will be no significant difference between experimental and control groups on the variable of heterosocial anxiety, as measured by the S-R Inventory of Anxiousness.

Ho 3) There will be no significant difference on the variable of heterosocial self-esteem, as measured by the Social Self-Esteem Inventory.

Ho 4) There will be no significant difference between rapists and pedophiles in the experimental group on the variables of heterosocial skills, heterosocial anxiety and heterosocial self-esteem.

Sampling Procedures

Forty of the 63 residents in treatment in the sex offender program participated in this study. The criteria used to determine inclusion in the training module were:

(a) single, and

(b) heterosexual or bisexual.

Using a table of random numbers, residents were randomly assigned to either a treatment or control group. The treatment group was further divided randomly into two groups of 10 each in order to expedite the training.

Experimental Treatment

Co-Trainers

There were four trainers, two males and two females. A team comprised of one male and one female co-led each of the two treatment groups. The investigator and author of the module trained the trainers and consulted with them during the treatment.

The selection of trainers was based on their clinical experience and interest in social skills training. They participated in an eight-hour heterosocial skills workshop where they learned role playing techniques, the use of video-tape for feedback, and became familiar with the procedures of the training module. This workshop included experiential activities, with staff members participating in

a simulated and abbreviated form of the module that was used with residents.

The Social Skills Module

The training module consisted of eight two-hour sessions with objectives and step-by-step procedures outlined for each session. The module was developed primarily from the following:

1) Behaviors found to differentiate adequate from inadequate males on HSB (Barlow et al., 1977);

2) Ideas and concepts from the books Shyness (Zimbardo, 1977) and Contact: The First Four Minutes (Zunin, 1973).

3) Treatment methods used with shy and socially-anxious college males (Twentyman & McFall, 1975; Arkowitz, 1977);

4) Principles of cognitive behavior modification (Meichenbaum, 1977);

5) Results from a pilot study; and

6) Clinical experience of investigator with this population.

The six-week training module was comprised of eight lessons. It focused on the following general areas: conversation skills, self-esteem, body image, negative self talk, and anxiety. The seventh lession was a social simulation (party) with female confederates. This lesson gave participants an opportunity to practice further the skills

gained in previous sessions. Role play was used extensively throughout the training.

There were eight lessons in the module (Appendix D). In general, they focused on the following: (a) introductions, setting group norms, individual needs assessments, role play skills; (b) assessment of personal strengths and weaknesses, establishing goals and action plans, introduction to skills checklist; (c) feedback on video role plays, assessment of skills and anxiety problems; (d) understanding and practice in effective listening and responding; (e) practice in initiation conversation, risk-taking, overcoming negative self-talk; (f) role play most feared heterosocial situation, critique and feedback; (g) social simulation (party with female confederates, practicing social conversation, risk-taking) and, (h) review of personal goals and action plans, more role play and critiques.

Confederates

In order to simulate actual social encounters and give participants a chance to reality test their skills, female volunteers were used during the training. The volunteers worked cooperatively throughout the training in role play situations. Mean age of the confederates was approximately the same as that of the offenders. Attempts were also made to provide volunteers representing appropriate racial/ethnic backgrounds. Each volunteer was given an orientation which included instruction and a brief role-play.

Criterion Instruments

Three criterion instruments were used: The Heterosocial Skills Behavior Checklist (HSB) (Barlow et al., 1977); The S-R Inventory of Anxiousness (SRIA) (Endler, Hunt, & Rosenstein, 1962) as modified by Arkowitz et al. (1975); and The Social Self-Esteem Inventory (SSI) developed by Lawson (1979) and modified for this study by the investigator to measure heterosocial self-esteem.

The Heterosocial Skills Behavior Checklist (HSB)

The HSB was developed to measure behaviors associated with initial heterosocial contact. It is designed specifically for males and provides a score which can be matched against norms established with heterosocially adequate and inadequate males (Barlow et al., 1977). Trained raters fill out the checklist while viewing five 30-second segments of a five-minute videotaped role play between a male subject and a female confederate.

The role play situation given both male and female is typically a party or a waiting room in which the male notices the female and decides to approach her. In each segment, the behaviors are rated as either present or absent in four areas: voice, form of conversation, affect and motor behavior. The female's instructions are to be rather pleasantly neutral and to let the male take the initiative. Responses to his statements are to be kept brief.

In the development of this instrument, 10 socially inadequate white males were selected, by staff agreement, from a group being evaluated for sexual deviation. Twenty adequate college and high school males, 10 black and 10 white, were also selected on the basis of agreement of five females who rated them as popular with their classmates. The two adequate groups, black and white males, scored high on the percent of appropriate behaviors (89.4 percent, s.d. 7.3), while the inadequate group averaged 71.2 percent appropriate behaviors (s.d. 8.8). Motor behavior was the only measure which did not significantly discriminate adequates from inadequates.

Alexander (1979) assessed the reliability of the HSB with a population of 79 sex offenders in treatment at the North Florida Evaluation and Treatment Center. Interrater reliability was found to be high (90 to 100 percent). Split half-reliability was also found to be high on three of the dimensions: affect, $r = .96$ and .87; voice, $r = .97$ and 1.00; and form, $r = .95$ and .79. Motor behavior was deleted in this study. Test-retest reliability was questionable because of the low score of form ($r = .90$, $p < .72$). Test-retest reliability for voice was ($v = .74$, $p < .00$) and affect ($r = .53$, $p < .02$).

In a psychometric analysis of the HSB, Coleman and others (1979) collected data on 67 sexual deviates. Therapists rated their videotaped interactions with females on a 1

(very poor skills) to a 5 (very good skills) scale. These ratings correlated moderately but significantly with ratings of voice, form of conversation and affect. Motor behavior did not correlate significantly (Coleman, Murphy, Abel, & Becher, 1979).

The HSB was modified by the investigator. Kupke and Sarason (1979) found that the frequency with which the male used the pronoun you in interaction with a female correlated significantly with her rating him as more socially skilled. This rating was added to the "interest" measure under "form of conversation." Motor behavior was deleted as well as the "inflection" measure under voice due to difficulty in differentiating it from other voice measures.

The S-R Inventory of Anxiousness (SRIA)

The SRIA is a self-report inventory developed by Endler et al. (1962). Recognizing that situations contribute more to the variance on the construct of anxiousness than individual differences, they developed an inventory that was situationally modifiable. On this measure, a situation is described such as, "You are about to be introduced to an attractive woman at a party." Fourteen response modes follow. For example:

1) Heart beats faster 1 2 3 4 5
not at all much faster

2) Get uneasy feeling 1 2 3 4 5
none very strong

Arkowitz (1975), in his study of social competence in males, using five heterosocial situations, found a significant difference between scores of high and low frequency daters using this modified version of the SRIA. In addition, he found SRIA scores to drop significantly as a result of training. The SRIA has been found to intercorrelate with other valid and reliable measures, such as the Social Anxiety and Distress Scale (SAD) and Fear of Negative Evaluation Scale (FNE) (Watson & Friend, 1969). Alexander (1979) found the SRIA to be less reactive to the tendency toward socially desirable answers than the SAD in use with sex offenders and changed less over time. In the same study, a test re-test correlation of .88 ($p < .0001$) was found. The SRIA correlated with the SAD, another self-report social anxiety measure ($r = .63$).

The Social Self-Esteem Inventory (SSI)

The 30-item Social Self-Esteem Inventory developed by Lawson, Marshall and McGrath was modified by the investigator for use in this study. All but six of the items were altered to make them specifically heterosocial in nature. For example, I am easy to like was changed to Females find me easy to like. There were 15 negatively keyed situations and 15 positively keyed.

The original inventory (SSI) yielded a test-retest reliability of .88. It was normed on a group of first-year

psychology students. Factor analysis of the 30-item scale revealed a single general factor that accounted for 39.7 percent of the total variance.

Analysis of the Data

A two-way analysis of variance was performed to test for experimental and control group differences and differences between rapist and pedophiles on the dependent variables. Statistical significance was set at the .05 level of confidence.

Equivalency between experimental and control groups was determined by t-tests of group means on the variables of age, length of time in treatment, race and offense.

Pearson product-moment correlations were performed to determine interrater reliability on the HSB Checklist following posttesting.

CHAPTER IV
RESULTS

The purpose of this study was to determine the effectiveness of a six week heterosocial skills training module with sex offenders. A randomized control group, posttest-only design was used and four major null hypotheses and three null sub-hypotheses were tested. The dependent variables of heterosocial skill, heterosocial self-esteem and heterosocial anxiety were drawn from three criterion instruments: (1) The Heterosocial Skills Behavior Checklist (HSB), (2) The Social Self-Esteem Inventory (SSI), and (3) The S-R Inventory of Anxiousness (SRIA).

Since the HSB total score is comprised of three areas (voice, form of conversation and affect), three null sub-hypotheses were tested in order to determine their relative contributions to any differences between experimental and control groups. The fourth major hypothesis tested for interaction between the treatment and type of offender (rapist or pedophile).

A two-way analysis of variance was used to test for differences between experimental and control groups following training, as well as how type of offense interacted with the treatment in the experimental group. Since two separate treatment groups were used with different sets of male/

female co-trainers, a t-test was used to determine effects of trainers. The t-test showed no significant difference between treatment groups on all three measures, thus the data were collapsed to form one experimental group (N = 18) for comparison with the control group. These results are presented in Table 4.1.

Resulting Sample

Group means of the total sample and the experimental and control groups with respect to age, months in treatment, race and offense are shown in Table 4.2. Of the original sample of 40 participants, data were gathered on 37; 18 experimentals and 19 controls. Two subjects in one of the treatment groups missed several sessions and were therefore excluded. One control subject exercised his right not to participate in the posttesting.

Since more pedophiles are exclusively homosexual and over 40 years of age, the only two selection criteria, the original sample (N = 40) had 25 rapists and only 15 pedophiles. After randon assignment, 11 pedophiles were in treatment groups and only four in the control. Also, the one control group participant who declined the posttest was a pedophile.

A total of five blacks participated in the study. However, data were collected on four, two in the experimental group and two in the control group. A separate two-way

TABLE 4.1
TESTS FOR EQUIVALENCY BETWEEN
EXPERIMENTAL GROUPS I & II

Variable	Groups	N	$\bar{X}$	S.D	T	D.F	pr>t
HSB Total	I	10	91.3	6.4	.01	10	.99
	II	8	91.2	12.1	.01	16	.99
SRIA	I	10	146.8	37.5	.04	15	.96
	II	8	146.	37.6	.05	16	.96
SSI	I	10	135.5	25.2	.34	.3	.73
	II	8	130.8	31.1	.34	16	.73

TABLE 4.2
GROUP CHARACTERISTICS AND EQUIVALENCY
BETWEEN EXPERIMENTAL AND CONTROL GROUPS

Group	N	Avg. Age	Months in Treatment	Black	White	Rapist	Pedophile
Total Sample	37	25.5	13.9	4	33	23	14
Experimental Group	18	26.1	15	2	16	8**	10**
Control Group	19	25.1	13	2	17	16**	3**

**Not equivalent at .05 level (Fishers Exact Probability)

analysis of variance was done with the white subjects only. No significant change was noted in the data, therefore, the blacks' data were included in the results.

General Findings

Equivalency

Equivalency between experimental and control groups was analyzed with respect to age, length of time in treatment, race and ratio of rapists to pedophiles. As reported in Table 4.2, groups were equivalent on all of the variables except ratio of rapists to pedophiles. The Fisher Exact Probability Tests showed significant group differences ($p < .01$) by types of offense.

Heterosocial Skill

The total percent appropriate scores on the HSB checklist were an average of the scores of the two raters, both of whom rated all of the tapes. Pearson product moment correlations were done to determine interrater reliability. Acceptable correlations were found for voice, form of conversation, and affect. These findings are presented in Table 4.3.

It was hypothesized that there would be no statistically significant differences between experiment and control groups on the variable of heterosocial skill, as measured by the HSB.

TABLE 4.3
INTERRATER RELIABILITIES
HSB CHECKLIST

Measure	Raters	N	$\bar{X}$	S.D.	r
Voice	I	37	96.3	7.6	.80
	II	37	93.6	9.7	
Form of Conversation	I	37	82.7	16.8	.87
	II	37	85.1	14.1	
Affect	I	37	85.8	16.8	.90
	II	37	82.9	18.1	

Total. The HSB total score is a combined percent appropriate score obtained from the three subscales of voice, form of conversation and affect. The experimental group scored 7.7 percentage points higher than the control group on HSB total. As presented in Table 4.4, the obtained F-statistic of 5.29 ($p > F.027$) was significant and the null hypotheses was rejected.

Voice. The voice measure was altered by deleting inflection since this measure was found to be difficult to rate in a pilot study. The remaining three areas rated were loudness, pitch and dramatic effect. A subject was rated inappropriate if, (a) he could not be heard clearly, (b) his voice was higher in pitch than the confederate's, or (c) he placed special dramatic emphasis on words, in any of the five 30-second segments.

The experimental group scored 4.7 mean percentage points, higher than controls on the voice measure. Due to the low dispersion of the scores in both groups (S.D. 5.0 and 9.8), the differences were statistically significant. The obtained F-statistic of 6.02 ($p > F.02$) was significant beyond the .05 level of confidence. Since it was hypothesized that there would be no significant difference between experimental and control groups on the voice variable, the null hypothesis was rejected.

Form of conversation. The form measure on the HSB is comprised of four behaviors: initiation, follow-up, flow

TABLE 4.4
ANALYSIS OF VARIANCE BETWEEN
EXPERIMENTAL AND CONTROL GROUPS,
HETEROSOCIAL SKILL, ANXIETY AND SELF-ESTEEM

Measure	Group	N	$\bar{X}$	S.D.	F	D.F.	p>F
HSB Voice	Exp.	18	97.5	5.0	6.02	1	.02*
	Con.	19	92.8	9.8			
HSB Form of Conversation	Exp.	18	88.0	13.9	2.49	1	.12
	Con.	19	79.8	14.9			
HSB Affect	Exp.	18	89.9	11.9	2.82	1	.10
	Con.	19	79.3	20.3			
HSB Total	Exp.	18	91.3	8.0	5.29	1	.02*
	Con.	19	83.6	11.2			
SRIA	Exp.	18	146.	36.4	.75	1	.39
	Con.	19	160.	54.1			
SSI	Exp.	18	133.4	27.2	1.08	1	.30
	Con.	19	120.2	39.4			

*Significant at .05 level.
Weighted cell means solution to ANOVA.

and interest. In order to be rated appropriate the subject must (a) initiate topics of conversation, (b) respond vocally at least once per 30-second segment to the female's vocalizations, (c) refrain from allowing pauses of over five seconds in each segment, and (d) make comments which demonstrate interest in the woman.

The mean percent appropriate scores on the form measure was 8.2 percent higher for the experimental group than the controls. Even though this appears to be in the probable direction, as presented in Table 4.4, the obtained F-statistic of 2.49 ($p > F.12$) was not significant at the .05 level of confidence. Since it was hypothesized that there would be no significant difference between experimental and control groups on this measure, the null hypothesis was not rejected.

Affect. The three behaviors that were the focus of attention in the affect ratings were racial expression, eye contact, and laughter. An appropriate rating was given to the subject, (a) whose facial expression was in accord with the topic of conversation and the female's expression, (b) who maintained eye contact for at least five seconds each 30-second segment, and (c) who refrained from high-pitched, nervous laughter.

It was hypothesized that there would be no significant difference between experimental and control groups on the variable affect, as measured by the HSB. The experimental

group mean on the affect measure was 10.1 percentage points higher than the control group mean. As presented in Table 4.4, the obtained F-statistic of 2.82 ($p > F.10$) was not significant at the .05 level of confidence. Therefore, the null hypotheses were not rejected.

Heterosocial Anxiety

The version of the S-R Inventory of Anxiousness used in this study requires the subject to imagine himself in five different situations which call for interactions with females. He reports how anxious he would be by rating the extent his heart would beat faster, that he would perspire, that his mouth would get dry, and so forth.

It was hypothesized that there would be no significant difference between experimental and control groups on the variable of heterosocial anxiety, as measured by the S-R Inventory of Anxiousness. Although the experimental group scored lower on the anxiety measure, differences between group means (14 points) were statistically minimal. As presented in Table 4.4, the obtained F-statistic of .75 ($p > F.39$) was not significant at the .05 level of confidence. Therefore, the null hypotheses was not rejected.

Heterosocial Self-Esteem

The Social Self-Esteem Inventory was modified for this study by attempting to make each statement relate to

confidence in situations which were specifically heterosocial. This was accomplished by replacing the word "people" with the word "female" or the "opposite sex."

It was hypothesized that there would be no significant difference between experimental and control groups on the variable of heterosocial self-esteem as measured by a modified version of the Social Self-Esteem Inventory. Although the experimental group mean was 13 points higher than the control group on the SSI, this difference was not statistically meaningful. As presented in Table 4.4, the obtained F-statistic of 1.08 ($p > F.30$) was not significant at the .05 level of confidence. Therefore, the null hypotheses was not rejected.

Treatment/Offense Interaction

In order to determine if any differences existed between rapists and pedophiles in response to the heterosocial skills training, an analysis of variance was performed on the experimental group by offense.

It was hypothesized that there would be no significant difference between rapists and pedophiles in the experimental groups on the variables of heterosocial skill, heterosocial anxiety and heterosocial self-esteem. The results are presented in Table 4.5. The null hypotheses was not rejected on all three variables. The F-statistic for HSB total was 2.20 ($p > F.14$), for SRIA $F = .02$ ($p > F .88$) and SSI $F - .00$ ($p > F.98$).

TABLE 4.5
ANALYSIS OF VARIANCE OF TREATMENT
OFFENSE INTERACTION

Measure	Offender	N	$\bar{X}$	S.D.	F.	D.F.	p F
HSB Total	Rapists	8	94.8	5.8	2.20	1	.14
	Pedophiles	10	88.5	10.5			
SRIA	Rapists	8	143.5	38	.02	1	.88
	Pedophiles	10	148	37			
SSI	Rapists	8	133.5	32.8	.00	1	.98
	Pedophiles	10	133.4	23.7			

CHAPTER V
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

Forty sex offenders in the North Florida Evaluation and Treatment Center participated in a study to test the effectiveness of a six-week heterosocial skills training module. A randomized control group, posttest-only design was used to determine the effects of training on heterosocial skills, anxiety and self-esteem. Four major null hypotheses and three null sub-hypotheses were tested. Of these, one major hypothesis and one sub-hypothesis were rejected. Both HSB total score and the voice subscale score showed a significant difference between experimental and control groups with the experimental group scoring higher.

No significant differences were found between experimental and control groups on the S-R Inventory of Anxiousness or the modified Social Self-Esteem Inventory. Also, no significant differences were found between rapists and pedophiles in the experimental group.

Equivalency

To test for equivalency between experimental and control groups, t-tests were performed. Four factors were

studied which could produce group differences on the post-test measures: age, length of time in treatment, race and type of offense. For the most part, the experimental and control groups were equivalent. Only on the variable of "type of offense" did a significant difference occur (.05 level). This might be attributed to randomization procedures. No attempt was made to control for this aspect of equivalency because of the requirements of the randomized posttest-only design. To maintain the integrity of the randomization, no attempt was made to reassign subjects. Out of the 40 participants in the study, 25 (60 percent) were rapists and 15 (40 percent) were pedophiles. However, after random assignments, 64 percent of the rapists were assigned to the control group and 73 percent of the pedophiles to the experimental group. The only attrition in the control group was a pedophile, so the final composition of the control group by offense was 84 percent rapist. This was a potential source of bias in interpreting the data <u>if</u> offenders' response to treatment differed significantly by offense. Yet, this may not be a negating factor.

In testing rapists and pedophiles, Alexander (1979) found differences on the HSB and SRIA with sex offenders according to age, however, no differences were found by offense. In addition, no significant treatment/offense interactions were found in the present study. Given these data and the established equivalency as to age, length of time

in treatment and race, the lack of equivalency as to offense between experimental and control groups was not considered a significant hinderance to drawing conclusions from the data.

Trainers and Training Process

The experimental group was divided into two training groups, each of which had its own set of male/female co-trainers. Procedurally trainer effect was controlled by: (a) selecting sets of trainers equivalent in age, training, and experience; and (b) stressing standardized procedures and time lines in the lessons of the training module. In addition, both training groups were brought together for Lesson #7, the Social Simulation . Trainer effect was determined statistically by comparing experimental groups I and II on all dependent variables. The result of t-tests showed no significant differences between the two experimental groups. This suggested that both training groups could be combined for comparison with the control group for data analysis.

The two sets of male/female co-trainers, all paraprofessional staff in the sex offender unit, participated in four hours of in-service training to learn the module. These trainers had already worked with sex offenders, had B.A. college degrees and had at least some experience in conducting small training groups. As treatment progressed, the

investigator met with each set of trainers, consulted with them and prepared for the next lesson.

Between sessions, the offenders were videotaped in brief simulated social encounters with female volunteers with whom they were not acquainted. During the first few training sessions, some time was devoted to playback and critique of these tapes. This feedback provided a reality check on the offender's level of skill or comfort with an unfamiliar female partner.

Although the eighth and final review session completed lessons, the climax to the training was the Social Simulation. Both training groups combined and were scheduled in half hour shifts to attend a social mixer with six females (five white and one black). These volunteers were recruited from outside the institution and from other units than the sex offender unit within the institution. Music and refreshments were provided and the participants were instructed to get to know as many of the females as they could. This lesson provided needed reality testing of gains made during the previous lessons.

Data Collection

HSB. In using the HSB checklist, Alexander (1979) found that the videotaped role play experience affected performance on self-report measures. Therefore, the posttest videotaping was conducted after the SRIA and SSI were

administered. Three women, two white and one black, all attractive and in their early to mid-twenties were used as confederates in the role play conversation. None of the women were acquainted with the subjects. One white female was taped with 28 of the participants. Since she could not finish, the remaining four whites (two experimental and two control) were taped with another female. The four blacks were taped with a black confederate.

Instructions were the same for all three confederates. They were instructed to be pleasant but restrained and to refrain from initiating conversation unless a 10-second silence occurred. At that time, they were instructed to ask the subject the location of his home town or some other similar question. This occurred on six occasions with six different subjects and was successful in getting the conversation flowing once again.

The videotaping was done as unobtrusively as possible through a two-inch hole cut in paper which covered the window to a small inner office. Each subject was told the following: "Imagine that you are on the outside and at a party. You notice an attractive woman alone and decide to approach her. Maintain a conversation with her for about five minutes" . . . the investigator did the briefing and the videotaping.

As called for in using the HSB Checklist, the completed videotapes of the in vivo conversation were divided into

five 30-second segments for rating purposes. This was accomplished by erasing five-second sections at carefully timed 30-second intervals. Rating was initiated at the first verbal exchange. The two raters, both white females ages 23 and 28, participated together in two hours of training which consisted of rating training tapes and discussion of definitions. Raters were both employees of NFETC. One was in her first few days of work, and the other worked in a different section of the Center. Neither was acquainted with the participants or had any knowledge of which subjects had received the training.

Ratings were done independently and each rater rated all tapes. Both raters reported the most difficulty with the affect variable. Judging the appropriateness of facial expression and laughter frequently depended on the content of the conversation and the affect of the female. Interrater reliability was .90 despite the difficulty.

The voice rating presented problems also. Specifically, both raters reported difficulty in determining if dramatic affect was being demonstrated. Possibly because of this difficulty, the Pearson Product Moment Correlation for voice was .80. According to the raters, form of conversation seemed to be the easiest to rate. The interrater reliability for form was .87.

Conclusions

The training module designed for this study was effective in increasing the heterosocial skills of the participants. Mean total score differences on the behavioral measure, the HSB Checklist, were significantly higher for the experimental group when compared with controls. The data indicate that of the three HSB subscales, voice accounted for more of the variance than either the form of conversation or affect measures. However, in comparison with the previous norms, (Barlow et al., 1977) the relatively high (92.8 percent appropriate) voice score of the control group indicates the possibility that no marked deficits in this area existed for either group prior to training. Apparently any deficits that did exist in the experimental groups were effectively remediated by the training, accounting for the very high mean (97.5 percent appropriate) score of the experimental group on the voice measure.

Control group mean scores on the form of conversation and affect subscales were relatively low. Although experimental group scores on these two measures were in the desired direction, neither met the .05 level of significance. It is possible that the skills measured by the form and affect subscales require more practice than the training provided.

It was anticipated that self-reported anxiety would significantly decrease and self-esteem would increase as a result of training. However, neither of these results

occurred. One explanation is that training affected the participants' self-assessments in an unanticipated direction. For example, a participant with unrealistically high self-assessments regarding heterosocial skill and comfort levels prior to training, could report a decrease in self-esteem or an increase in anxiety. The posttest-only design prohibited examination of individual increases or decreases on these measures. It is also possible that the SRIA and the modified SSI lacked the sensitivity necessary to measure the effects of the training.

Finally, regarding treatment/offense interaction, the data indicate that both rapists and pedophiles can benefit equally from heterosocial skills training. Although rapists outscored pedophiles slightly on all measures, no differences approached significance.

Limitations

The artificiality inherent in institutions presents treatment problems. Opportunities to put into practice new behaviors and reinforce progress are limited. This constraint may be a limiting factor in generalizing the final results, particularly to non-institution settings.

Racial differences were dealt with during the training and during posttesting by having black females available for role play purposes. Statistically, the results were analyzed with and without data from the four black participants

(two control and two experimental). Since no significant differences as to race were found, the data from the blacks was included in the final results. Although attempts were made to gear the training and the posttest videotaping to the black participants by using black female confederates, the problem of subcultural difference in heterosocial values, attitudes and behaviors remains a limitation in this study. It was clear that many of the skills learned are not subculture or class specific, such as listening, speaking clearly, etc. However, the trainers reported that the blacks, the latins and whites appeared to have varying definitions of appropriate heterosocial behavior. All of these concerns are viable but not addressed in this study.

It is the investigator's belief that many of the problems dealt with in the treatment would also apply to those who are exclusively homosexual. However, those with exclusive homosexual preference, with no aspirations toward heterosexuality were excluded from participation in this study. Therefore, conclusions are limited to heterosexual populations of sex offenders.

The complex process involving the use of the HSB Checklist had several potential sources of error that are difficult to control and could place limits on the findings: (a) the effects of differences between confederates in the video role play, (b) lack of complete standardization of the

role play conversation, and (c) participant's varying reaction to being videotaped.

Another problem encountered in this process was the inability of the white female confederate to complete the role play with all of the white subjects. Another female that met the same requirements regarding age, stranger to subjects, attractiveness, etc., was recruited. Only two experimental subjects and two controls remained to be taped so any differences resulting from a different confederate were appropriately distributed between groups. However, the investigator views this lack of standardization in confederates a limitation in this study.

Implications

There is a need to rehabilitate sex offenders to decrease their dangerousness and to help them become more responsible citizens. The sex offender literature points clearly to interpersonal problems, particularly in the heterosocial sphere, as being of critical concern in treatment. The present study demonstrates that, in an institutional setting, with minimum cost in terms of staff time and money, and with brief training, an eight lesson training course can be effective in helping sex offenders increase their heterosocial skills.

In addition, the training group approach is supported as a treatment modality. Systematic training modules, with

clear and measurable objectives, are a practical and cost effective method of treatment. Although this type of treatment is not designed to replace indepth therapy with its individual focus, the training group approach is standardized and can be replicated. It can also be implemented by paraprofessional staff.

A major problem in treatment programs in institutional settings is staff and resident morale. Part of the reason for this is the ambiguous nature of the growth and change process, both in terms of treatment objectives and the methods for achieving objectives. The response to the module by both the staff and the residents was enthusiastic. Part of that enthusiasm may have been related to the close relationship between content and offender inadequacies. There was clearly a "felt need" for this type of training. Part of the enthusiasm was also attributed to a rationale that was clearly understood, objectives that were precisely stated and behavioral methods of measuring the outcomes of treatment. This type of treatment might be a partial solution to the morale/burnout problem among both patients and staff in some institutions.

Recommendations

Further research is needed in identifying which specific behaviors within the voice, form and affect variables

account for most of the differences between adequate and inadequate performance. This may lead to refining the treatment module and an increased sensitivity of the measure.

More exploration needs to be done of the complex interaction between anxiety, skills deficits and negative self-talk. Each person has a unique process involving most of these elements to varying degrees. The challenge is to diagnose this process and prescribe appropriate treatment. Also, since important therapy issues surface as a result of the feedback in this training, interface with other treatment personnel and modalities is important. Deeper, more intrapsychic issues are often triggered in training, and these may need special attention in other therapeutic sessions.

Some attention should be focused on subcultural difference among offenders. Unless this is done by the trainers during training, a one-dimensional view of what is considered "correct" behavior can be engendered. Within this limit, flexibility is necessary with groups of participants from diverse backgrounds.

When using female volunteers as confederates in the role plays and simulations, careful attention should be paid to their preparation. This would insure optimal standardization during the treatment and data collections. In addition, the volunteers would have fewer problems in coping with the inevitable stress resulting from their roles in the process.

This training should occur early in an offender's treatment in order to insure an accurate assessment of his heterosecial adequacy. Easy access to talks with female paraprofessional staff within the artificial institutional environment has potentially negative consequences. A false sense of confidence could be engendered, especially given the capacity of offenders to distort any interactions with females.

Treatment objectives for homosexual rapists and pedophiles often include the development of appropriate adult homosexual behavior. Sufficient differences exist between the heterosexual and homosexual worlds, making specialized training necessary. A homosocial skills training module would meet the needs of this type of offender.

Research of this type should be done to test the effectiveness of other training modules such as assertiveness training and stress management training. Improvement in the effectiveness and efficiency in the delivery of treatment services could result.

This type of training and institutional treatment in general, would be less necessary if interpersonal problems, particularly in the trauma laden heterosocial sphere, were dealt with at an early stage of development. The family, the community and especially the schools can play important roles. The socially shy, withdrawn or aggressive 14 year old could adjust on his own at 15, or he could retreat into

a world of fantasy and sexual deviation. Communities and schools need to develop early intervention programs for these youths which apply some of the methods found most successful in institutional programs.

Heterosocial skills training is only one aspect of sex offender treatment. The psychological problems of sex offenders are intense and complex. Group therapy and the therapeutic environment of a comprehensive program are necessary for rehabilitation to be successful. Heterosocial skills training can be an important adjunct to this type of program.

APPENDIX A
HETEROSOCIAL SKILLS BEHAVIOR CHECKLIST FORM
INCLUDING RATER INSTRUCTIONS AND RESPONSE DEFINITIONS

Instructions

Each block represents 30 seconds of taping time. Do not make any marks on the sheet while watching a 30-second segment. Wait until the tape has been stopped before rating. If one inappropriate behavior occurs within the 30-second block, the entire block is rated inappropriate.

VOICE

///////	Loudness: loud enough to be heard clearly without "breathy" overtones or "whispery" quality.	///////	Loudness: cannot be clearly heard and/or "breathy" quality or "whispery" overtones.
///////	Pitch: lower in pitch than female companion's voice.	///////	Pitch: higher in pitch than female companion's voice.
///////	No special dramattic effects.	///////	Excessive emphasis on words rendering a special dramatic effect.

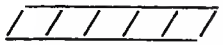
FORM OF CONVERSATION

///////	Initiation: male initiates conversation when female is not speaking and/or he introduces new topics that are discussed.	///////	Initiation: male fails to initiate conversation and female introduces all new topics.

///// Follow-up: male responds at least once to female's vocalizations.	///// Follow-up: male fails to respond vocally to female's vocalizations.
///// Flow: male does not allow uncomfortably long pauses or silences during breaks in conversation (5 seconds or more).	///// Flow: male often is speechless and allows conversation to break off (pauses of 5 seconds or more).
///// Interest: male makes some comment(s) indicating interest in the female (includes compliments about appearance, dress, activities, performance at work or school, questions asking female about herself and/or open-ended statements whose purpose is to reflect conversation to the female to talk about herself) uses pronoun YOU.	///// Interest: male does not make any comment(s) indicating interest in the female (no compliments about appearance, dress, activities, performance at work or school, no questions asking female about herself, and/or no open-ended statements whose purpose is to reflect conversation to the female to talk about herself). Fails to use pronoun YOU.

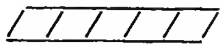
AFFECT

///// Facial: male's facial expression in accord with situation and female's expression (e.g., humorous topic of conversation --S should have a smile on face, not a serious expression. Serious topic of conversation--S's face should be composed and he should not laugh or smile).	///// Facial: male's facial expression not in accord with present context or female's expression.

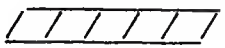


Eye contact: S looks at female when she is talking, for 5 seconds or more in the 30-second block.

Laughter: in a controlled manner with no giggling or high-pitched laughter.



Eye contact: S looks at female less than 5 seconds during the 30-second block.



Laughter: giggles or laughs in a high-pitched manner, staccato and uncontrolled.

APPENDIX B
S-R INVENTORY OF ANXIOUSNESS

This inventory represents a means of studying people's reactions to and attitudes toward various types of situations. On the following pages are represented situations which most people have experienced personally or have heard about through stories, etc. For each of the situations certain common types of personal reactions and feelings are listed. Indicate in the alternatives, representing the five points on the scale shown in this booklet, the degree to which you would show these reactions and feelings in the situations indicated.

Here is an example:

You are about to go on a roller coaster.

	1	2	3	4	5
Heart beats faster	not at all				much faster

If your heart beats <u>much faster</u> in this situation, you would circle alternative 5; if your heart beats <u>somewhat faster</u>, you would circle either alternative 2, 3, or 4, depending on <u>how much</u> faster; if in this situation your heart does not beat faster <u>at all</u>, you would circle alternative 1.

If you have no questions, please turn to the items on the following pages.

(Subjects respond to the following five questions. With <u>each</u> question, they fill out the 14 responses below)

1. You are introduced to an attractive girl and left to make conversation with her for a few minutes.

2. You are calling a woman you like a lot to ask her to do something with you.

3. You are trying to make casual conversation with the woman in line in front of you at the bank.

4. You are in line at a grocery store, a woman turns to you and comments about the high price of food.

5. You go to the beach or poor and there is a nice-looking woman that you would like to get to know better.

1.	Heart beats faster	1	2	3	4	5
		Not at all				Much faster
2.	Get an "uneasy feeling"	1	2	3	4	5
		None				Very strongly
3.	Emotions disrupt action	1	2	3	4	5
		Not at all				Very disruptive
4.	Feel exhilarated and thrilled	1	2	3	4	5
		Very much				Not at all
5.	Want to avoid situation	1	2	3	4	5
		Not at all				Very much
6.	Perspire	1	2	3	4	5
		Not at all				Perspire much
7.	Need to urinate frequently	1	2	3	4	5
		Not at all				Very frequently
8.	Enjoy the challenge	1	2	3	4	5
		Enjoy much				Not at all
9.	Mouth gets dry	1	2	3	4	5
		Not at all				Very dry
10.	Become immobilized	1	2	3	4	5
		Not at all				Completely

11.	Get full feeling in stomach	1	2	3	4	5
		None				Very full
12.	Seek experiences like this	1	2	3	4	5
		Very much				Not at all
13.	Have loose bowels	1	2	3	4	5
		None				Very much
14.	Experience nausea	1	2	3	4	5
		Not at all				Much nausea

APPENDIX C
THE SOCIAL SELF-ESTEEM INVENTORY
(Lawson, Marshall and McGrath)

(Modified to measure Heterosocial Self-Esteem)

NAME_____

Please circle one of the numbers to the right of the statements below according to the following scale:

COMPLETELY UNLIKE ME 1 2 3 4 5 6 EXACTLY LIKE ME

For example, if you felt like a statement described you exactly you would circle the (6). If the statement was completely unlike you, then you would circle the (1). The numbers 2 through 5 are different degrees of "LIKE YOU." Please choose the number that best describes your similarity to the following statements:

		Completely unlike me					Exactly like me
1*	I find it hard to talk to females I don't know	1	2	3	4	5	6
2*	I lack confidence with the opposite sex	1	2	3	4	5	6
3	I'm socially effective with females	1	2	3	4	5	6

*These items are negatively phrased, and they are scored by subtracting the number placed against them from seven.

		Completely unlike me					Exactly like me
4	I feel confident in social situations involving the opposite sex	1	2	3	4	5	6
5	Females find me easy to like	1	2	3	4	5	6
6	I get along with females	1	2	3	4	5	6
7	I make friends with females easily	1	2	3	4	5	6
8	I am lively and witty in social situations and with the opposite sex	1	2	3	4	5	6
9*	When I'm with females I lose self-confidence	1	2	3	4	5	6
10*	I find it difficult to make friends with members of the opposite sex	1	2	3	4	5	6
11*	I'm no good at all with females socially	1	2	3	4	5	6
12	I'm a reasonably good conversationalist with females	1	2	3	4	5	6
13	I'm popular with females my own age	1	2	3	4	5	6
14*	I'm afraid of large parties	1	2	3	4	5	6
15	I truly enjoy myself at parties	1	2	3	4	5	6
16*	I easily say the wrong thing when I talk with members of the opposite sex	1	2	3	4	5	6
17	I am confident at parties	1	2	3	4	5	6
18*	I'm usually unable to think of anything interesting to say to females	1	2	3	4	5	6
19*	I'm a bore with most females	1	2	3	4	5	6
20*	Females do not find me interesting	1	2	3	4	5	6

		Completely unlike me					Exactly like me
21*	I'm nervous with females who are not close friends	1	2	3	4	5	6
22	I'm quite good at making females feel at ease with me	1	2	3	4	5	6
23*	I am more shy with members of the opposite sex than most guys	1	2	3	4	5	6
24	I am a friendly person	1	2	3	4	5	6
25	I can hold a female's interest easily	1	2	3	4	5	6
26*	I don't have much personality	1	2	3	4	5	6
27	I'm a lot of fun to be with on a date	1	2	3	4	5	6
28	I am quite content with myself as a social person	1	2	3	4	5	6
29*	I am quite awkward in social situations	1	2	3	4	5	6
30*	I do not feel at ease with members of the opposite sex	1	2	3	4	5	6

APPENDIX D
SOCIAL SKILLS MODULE

Lesson #1: Goals, Contracts, Introductions

Objectives

1) To establish an atmosphere of trust and openness among the participants and between trainers and participants.

2) To explain and gain the participants' investment in the overall goals of the group and to help the participants develop their own personal goals and reasons for participation.

3) To generate a set of group rules and answer questions they have about the group.

4) To introduce participants to role play process.

5) To introduce the process of assessment of social skills and the important skills variables.

6) To begin preparation for Lesson #2.

Materials

1) Newsprint and easel
2) Magic markers and masking tape
3) Social skills workbooks
4) Demonstration role play videotape
5) Playback equipment

Procedures

1) After all participants have been seated in a circle, introduce yourselves to them.

2) Pass out the workbooks and ask them to turn to the first page. Read aloud the introductory statement.

3) Pass out pencils and tell them from now on they are to bring their workbooks and pencil or pen to each class. Have them respond to questions 1, 2, and 3 in the workbook.

4) Ask them to pick another participant or trainer that they don't know or know least well. Instruct them to do the following in pairs:

   a) Share their answers in the workbook.
   b) Come up with 3 or 4 group rules between them (give examples if necessary, i.e., no smoking, no put downs, start and end on time).
   c) List any questions they have about the group.

*Trainers participate in this exercise (10 minutes)

5) When 10 minutes is up exactly, get everyone back into the circle. Each person introduces his partner and his partner's answers to #1, #2 and #3. One trainer lists the expectations, rules and questions on newsprint as they are generated (15-20 minutes) during the intros. on separate sheets.

6) Trainer goes over expectation list to see how it:

   a) Coincides with course design. Makes some commitments to modify or add to meet participant's expectations.
   b) Trainer goes over the rules, reduces overlap and tries to negotiate conflicts in needs. (Both trainer's needs and expectations will be included and should be given equal weight with participants) (10 minutes). Once rules have been agreed upon, state that "This is our contract with each other for the next six weeks." These rules should be typed and handed out at the next session. Emphasize that everyone shares equal responsibility for monitoring the rules.
   c) Answer the questions generated, making note of any questions that couldn't be answered.

Lesson #2: Enhancing Your Social Appeal

Objectives

1) To assess each participant's perceived physican and behavioral strengths and weaknesses.

2) To give each participant a critique and group feedback concerning their perceived strengths and weaknesses.

3) To establish realistic goals and action plans based on critiqued strengths and weaknesses.

4) To get practice at assessing social interactions and reinforce the key skills.

Materials

1) Social skills workbooks
2) Video playback equipment and tapes of volunteers' role plays.

Procedures

1) Open up by asking for questions they have about the homework. Ask about whether or not it was helpful, etc.

2) Ask for a volunteer, if someone hasn't already started, to share a summary of their self-assessment and what they got out of it. Ask them if they would be open to receiving feedback from the group about how the group sees them, the group's feeling about how realistic their assessment is, etc. If they are open, facilitate this process and keep it constructive.

3) Break group into triads and have them share with each other in the same way as the volunteer has.

4) Instruct them after 10-15 minutes that each participant must come up with the following:

   a) A list of physical pluses they want to enhance,
   b) A list of physical minuses they want to improve,
   c) A list of physical minuses they must accept.

   Refer them to Action Plan in the workbook.

5) Get group back together and ask them to pick one item from one list that they want to work on before next session and announce it. Tell them that each session for the next 5 or 6 sessions of the training they will be asked to pick one thing and work on it. Each session will start off with sharing of progress on improving and accepting. (Trainers make note of each participant's item and plan so you can ask them next session.)

6) Tell group to get out their workbooks and turn to social skills checklist. Introduce the video tape by explaining how it was done and how it will be used. (Check with the two volunteer participants who are on the tape before class to see if they are still comfortable with the class seeing it.

7) Ask the two volunteer participants to briefly share their experiences with the group.

8) Play one of the video tapes all the way through and ask the group to fill out checklist at the end.

9) Go back over it and emphasize key points that are obvious in the tape (eye contact, listening, appropriate and inappropriate affect and other signs of anxiety).

*Time may permit only one tape being shown; therefore, pick the one first that illustrates the major points best.

10) Tell the rest of the group that they will have an opportunity to be taped before the next session. Emphasize that it's important to learn to risk in this setting and it's important in order to help them to find out what their major problems are.

Lesson #3: Why Am I Shy: The 3 Basic Areas

Objectives

1) To get direct feedback on their performance in video role plays and assess strengths and weaknesses in skills and anxiety areas.

2) To give practice role playing and risk taking.

3) To assess the major problem areas, i.e., skills, anxiety, negative self-talk.

Materials

1) Video playback equipment and taped roleplays between volunteers and participants.
2) Social skills workbooks
3) Extra Social Skills Checklist

Procedures

1) Ask about their progress on the items from their list of physical pluses and minuses. Have them each share briefly their progress or lack of it.

2) Ask each one to briefly share his experiences in the roleplay.

3) Start playing the tapes. Have them turn to their checklists for rating. Stop the tape when something important happens, i.e., a silence (ask, "What were you thinking, how were you feeling?") Ask participants how they might have responded differently. Check on their ratings of eye contact. Answer questions thoroughly until you see understanding.

4) After about one-half hour of going over tapes, stop and ask them to turn to their homework, Why Am I Shy?

5) Put all of their names on the newsprint and ask them to tell you the number of the statements they checked on the "Why Am I Shy" homework. See if there are any clusters (3 ones, two 1's and 2's). If there is a logical way to break them up, ask them to get in cluster groups and begin sharing why they checked the statements that they did. *Tell them to recall their roleplay as examples.

6) After 10-15 minutes, ask each group to share what they've come up with as to why they might be shy. Explain the three basic areas very briefly and get them to identify which is the biggest problem for them or what combination of problems they have. Points to make in presentation: Social competency means 1) feeling good about yourself, 2) being relaxed, 3) knowing what to say, and 4) listening.

   The three areas are:

   (a) Anxiety: The person who is socially anxious may know the correct way to act to be successful, but he gets stage fright and either withdraws or behaves in a way which elicits pity or turns the woman off.

   (b) Skills: The person who is low in skills hasn't had enough practice in these situations to know how to behave. They are like an actor who hasn't studied his lines. Sometimes they say things that are not appropriate for the situation, get too aggressive, etc.

(c) Negative Self-Talk: This person's problem is self-esteem. They defeat themselves before they start by telling themselves they will get shot down, they aren't good enough, she must have a boyfriend already, etc.

7) Have them answer the question at the end of "Why Am I Shy" based on what they've learned so far.

8) Have each participant read what they've written. Help them clarify what their problem is from the four questions in Why Am I Shy. Make a note of which area or areas in which each of them have problems.

9) Homework: Continue self-improvement and do listening homework.

Lesson #4: Learning How to Listen

Objectives

1) To continue self-improvement plans.

2) To help participants develop an understanding of effective listening and responding.

3) To give participants practice in effective listening.

Materials

1) Social skills workbooks.
2) Magic marker and easel.

Procedures

1) As in previous lesson, go over their self-improvement Action Plan asking each person to relate what physical pluses or minuses they worked on and what they did. Reward those who did the homework with praise. Stress how important it is to stick with things. Check to see if some of their plans are realistic. (10 minutes)

2) Ask them to get out their Listening homework.

3) Have the female co-trainer read the first statement and ask each participant to read his response.

4) After all participants have done this go to the easel and, using the first statement, ask them what the feeling was that has been expressed. Write down their responses and then ask which one expresses it best. (Probably bored or dissatisfied would express it best). Go through the rest of the statements similarly then explain that nearly everyone expresses both words or Content and Feeling when they talk.

   An effective way of listening is to let the other person know that you not only heard the words but also the feeling.

5) Go back over the Listening homework and get them to start their response with You and then add the feeling.

   Example:

   1) You're dissatisfied with the jobs you've had so far.
   2) You're eager to find out about different places or you're bored with this town.
   3) You're interested in traveling.
   4) You like this kind of weather.

6) Spend the rest of the time with practice picking out the feelings and feeding them back.

   Points to make:

   (a) People feel good about you if they sense that you're interested in them enough to listen and understand.
   (b) This isn't all you do in a conversation (think how silly that would be), but it's one important thing you can do. It builds some trust and bridges gaps.

Lesson #5: Risking and Starting a Conversation

Objectives

1) To explore their catastrophic expectations surrounding rejection.
2) To help them develop a risk taking attitude.
3) To give them practice in initiating conversation.

Materials

1) Magic markers and easel.

Procedures

1) Go over their self-improvement goals for the week. Take a general survey about how that is going. If it's worthwhile, what things are keeping them from doing it (10 minutes).

2) Introduce the next section by putting the female co-trainer in a chair and putting an empty chair about 6 feet away. Ask for a volunteer to sit in the empty chair. Ask the volunteer to imagine that he is in a waiting room or a bar or wherever he wants, and is lonely and attracted to this woman. Ask him to verbalize all the thoughts that usually go through his head in this kind of situation. Repeat with one or two other volunteers (15 minutes).

3) After this have the group brainstorm all the reasons why they don't take interpersonal risks. What's at stake? What are they afraid of losing? Discuss these with them and ask them how they feel about these reasons (10 minutes).

4) Make the point that one of the things this course is about is taking risks. You can lose, but you can win too. (You're surely not going to win if you don't risk!!!)

5) Recreate the scene again (2 chairs). Get the group to choose a person this time and ask them to huddle. They are to give their "volunteer" an opening line. He is to use his listening skill and his brain to do the rest.

6) After he has done this, remind them of the key points--eye contact, listening and responding to her, relaxation, overcoming negative self-talk.

7) Repeat this several times with as many participants as time allows. Allow them to have fun with this exercise. A light atmosphere will decrease the tension usually connected with this situation.

8) Give assignment to be ready to describe their most threatening heterosocial situation at the beginning of Lesson #6.

Lesson #6: Most Feared Situation

Objectives

1) To increase confidence in dealing with threatening interpersonal situations.

2) To desensitize participants to irrational fears associated with heterosocial situations.

3) To reinforce key principals of heterosocial skills.

Materials

1) Newsprint and magic marker
2) Extra chairs

Procedures

1) Have the whole class describe their most threatening heterosocial situation one by one. Help each one clarify exactly what the situation is, then summarize it by his name on newsprint. Try to define the unique elements of each participant's situation.

2) Ask for a volunteer who would like to role play this situation.

3) Keep the role play simple. Make sure all key elements in the role play know basically what to do; especially the female co-trainer.

4) Try to do as many of the participant's scenes as possible, giving feedback and allowing each participant to talk about his feelings afterward. Tie in any important points related to material already covered. Let the female give feedback as to strengths and weaknesses she perceived in his performance.

5) Leave at least 15 minutes at the end of class to have a general discussion about the meaning this experience had for them. Reinforce key ideas such as negative self-talk, eye contact, listening, risking, etc.

6) Give an overview of the next lesson, the Social Simulation. Develop some ground rules with them as do's and don'ts, i.e., no physical contact, no attempts to get addresses or phone numbers.

Lesson #7: Social Simulation

Objectives

1) To give participants an opportunity to practice the new skills they've acquired.

2) To check what problem areas still remain for further work.

3) To simulate a real social encounter and to reality test their perceptions of themselves and their newly acquired skills and understandings.

Materials and Resources

1) Record player
2) Refreshments
3) Cluster seating
4) Six to eight female volunteers

Procedures

1) Seating, music and refreshment should be arranged beforehand.

2) Female volunteers should be instructed to be positive, but somewhat passive; generally allowing the residents to initiate contact and maintain interactions.

3) Have several male and female staff present. This will allow some easier transitions from contacts with familiar to non-familiar people.

4) Residents should not be pushed, but encouraged from time to time to both cut off communications that have gone on for more than 10 minutes and to initiate contact if they've failed to do so.

Lesson #8: Review

Objectives

1) To work on any issues which surfaced during the simulation.

2) To review the key points of the Social Skills Training.

3) To develop personal action plans for continued work on Social Skills.

4) To collect self-report data.

Materials

Procedures

1) For the first one to one and one-half hours, deal with issues which surfaced during the simulation. Role play the problems, rather than "talk about" them.

2) Use the things they bring up to reinforce some of the key points made during the previous lessons:

   a) Risking rejection
   b) Appearance
   c) Listening, eye contact
   d) Negative self-talk

3) Ask the group to spend about 10 minutes coming up with an "action plan" for further work.

APPENDIX E
PARTICIPANT WORKBOOK

Introduction

The purpose of this training group is to help you become better able to approach and make social conversation with females. There are problems in this area that are common to all of you, but each of you also has your own special problems. This group will help each of you work out your own problems and your own solutions.

Lesson 1

Please answer the following question:

(1) What would you like to get out of this group?

(2) I think the following group rules would make this group work best.

(a)

(b)

(c)

(3) Do you have any general questions that relate to this group?

Social Skills Checklist

Form of Conversation

1) Did he bring up new topics to discuss or did he let her take the lead in what to talk about?

#1	#2		#1	#2	
☐	☐	He started conversation or new topics	☐	☐	She had to

2) Does he respond to her when she talks or does he fail to respond to her?

#1	#2		#1	#2	
☐	☐	Responds	☐	☐	Failed to respond.

3) Does he allow long pauses (5 seconds or more) or does he fill these somehow?

#1	#2		#1	#2	
☐	☐	Allows long pauses	☐	☐	Doesn't allow long pauses

4) Does he make comments which show interest in her or ask questions which call for information about her or does he fail to do this? How often does he use the word <u>you</u>?

#1	#2		#1	#2	
☐	☐	Shows interest	☐	☐	Fails to show interest.

Affect

1) Does his facial expression match what is being discussed or is his expression inappropriate to the topic?

#1	#2		#1	#2	
☐	☐	Facial expression	☐	☐	Facial expression inappropriate

2) Does he look directly at her for at least 5 seconds each 30 seconds or not?

#1	#2		#1	#2	
☐	☐	Looks at her	☐	☐	Doesn't look at her

3) Does he laugh in a controlled manner or does he giggle or laugh in an uncontrolled or high pitched manner?

#1	#2	Controlled laugh	#1	#2	Uncontrolled laugh
☐	☐		☐	☐	

Content

1) Was what he talked about during the conversation appropriate or inappropriate for the situation?

#1	#2	Appropriate	#1	#2	Inappropriate
☐	☐		☐	☐	

Assignment #1
Strengths & Weaknesses

Appearance

Starting with your hair, go over every part of your body including all facial features, skin, shoulders, arms, chest, stomach, penis, buttocks, legs, etc., down to your feet and list whether or not you feel it is a plus or a minus, and why. Pluses are things you feel good about, and minuses are things you don't feel good about.
*Only put + or - next to those things you feel are real pluses or real minuses. Put a 0 beside neutral body parts.

hair_____	chest_____
eyes_____	back_____
nose_____	stomach_____
mouth_____	buttocks_____
teeth_____	penis_____
chin_____	thighs_____
ears_____	knees_____
skin_____	calves_____
neck_____	ankles_____
shoulders_____	feet_____
upper arms_____	General_____
forearms_____	_____
hands_____	

weight_____
height_____

Comments:_____
_____
_____

Self Improvement
Action Plan

Physical pluses that can be improved	Plan
1.	1.
2.	2.
3.	3.
4.	4.

Physical minuses that can be improved	
1.	1.
2.	2.
3.	3.
4.	4.

Physical minuses that I must accept	
1.	1.
2.	2.
3.	3.
4.	4.

Personality/skills pluses	How can I use them fully?
1.	
2.	
3.	
4.	

Personality/skills minuses	How can I turn them into pluses?
1.	
2.	
3.	
4.	

Pluses I can take advantage of

_____
_____
_____

Minuses I can change

_____
_____
_____

Minuses I must accept

_____
_____
_____

Personality

List the things about your personality, skills, or abilities that you like and are social pluses.

_____
_____
_____
_____

List the things about your personality you don't like and are social minuses

_____
_____
_____
_____

Why Am I Shy

Check the statement or statements you think most applies to you.

/__/ 1) I feel bad about myself so I think I'll be rejected and that keeps me from even trying.

/__/ 2) I don't know what to do or say or I'm worried that I'll say or do something stupid and be rejected.

/__/ 3) I think I know what to say but for some reason I get so scared when I'm around females that I freeze up.

/__/ 4) In most situations, it's just too much of a risk to be rejected.

If you checked more than one, which one is most like you? _____

*Wait for in-class discussion before you fill this out.

*Here's my biggest problem. When I am attracted to a female and have a chance to talk with her, I

_____

_____

_____

_____

_____

_____

Listening

Respond to the following statements the way you would normally respond in a social conversation with a female.

She says:

1) I've worked at all kinds of odd jobs but nothing has interested me much.

You say:

_____

_____

_____

She says:

2) I've lived in this same area all my life, sometimes I think I would like to live somewhere else.

You say:

_____

_____

_____

She says:

3) I read travel magazines and think about traveling a lot. Someday I'm going to do it.

You say:

_____

_____

_____

She says:

4) It's nice out today, isn't it?

You say:

_____

_____

APPENDIX F
INFORMED CONSENT-SOCIAL SKILLS GROUP

By signing this form you are agreeing to participate in a six week training group and study on social skills. There will be a total of eight two-hour sessions. During the training you will be practicing making social conversation with females. You will be asked to share your attitudes and feelings about yourself and your confidence with females. The purpose of the group is to increase your skills and confidence and decrease your anxiety in social contacts with females.

The social skills training group is voluntary. You are free to drop out at any time. You may be asked about your reason for dropping out, but the consequences will be no different than dropping out of any of the other training groups. You are also free to participate or not in any of the exercises or role plays within each session. The outcome of your participation in the group will form a part of your regular evaluation.

I have read and understand the procedures described above. I agree to participate in the procedure and I have received a copy of this description.

_____ _____

Name of Resident Date

_____ _____

Witness Date

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BIOGRAPHICAL SKETCH

Michael W. McAnaney was born September 11, 1946, in Altadena, California. At one year of age, he moved with his parents and older brother and sister to Wooster, Ohio, where he lived until the fall of 1959. That year, at age thirteen, he and his parents moved to Port Charlotte, Florida, where he attended Charlotte High School until graduation in 1964.

He attended the University of Florida from 1964 through 1971, receiving a B.A. in psychology and a master's degree in counselor education. Between 1968 and 1971, he worked in the Levy County Schools as a special education teacher and guidance counselor.

He began work in the drug abuse field in 1970 as graduate assistant at the Corner Drug Store in Gainesville. This interest took him to The Community Drug Project in Columbia, South Carolina. From there, he moved to Miami, Florida, where he worked as a trainer and eventually as Training Director of the S.E. Regional Training Center, a drug abuse prevention project funded by the U.S. Office of Education.

In 1976, he returned to Gainesville to work toward his Ph.D. After a brief time as supervisor of a small drug abuse program in Ocala, he began work as a therapist in the sex offender program at the North Florida Evaluation and

Treatment Center, one of three forensic hospitals in Florida.

From March of 1977 to the present, he has worked in NFETC's sex offender program, as a therapist and administrator. He is currently Director of the Sex Offender Unit at North Florida Evaluation and Treatment Center.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Robert D. Myrick, Chairman
Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Paul Joseph Wittmer
Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Benjamin Barger
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This dissertation was submitted to the Graduate Faculty of the Department of Counselor Education in the College of Education and to the Graduate Council, and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

December 1981

Dean for Graduate Studies and Research